

Policy #: 061

Original policy date: 1/1/09
Revised date: 10/1/09

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Title

Bisphosphonates, Infusion/Injection

Boniva[®] (ibandronate), infusion
Reclast[®] (zoledronic acid), infusion
Zometa[®] (zoledronic acid), injection

Note: Reclast[®] and Zometa[®] are not covered under the retail pharmacy benefit and must be billed under the medical benefit.

When services are covered

Boniva[®] (ibandronate), Reclast[®] (zoledronic acid)¹

We cover Boniva[®] (ibandronate) and Reclast[®] (zoledronic acid) for a documented diagnosis of osteoporosis in women or men (ICD-9 CM 733.00-733.09) when one of the following criteria is met:

- Previous treatment failure with one or more oral bisphosphonates (alendronate, Fosamax, Actonel) resulting in intolerance to the oral product **OR**
- Inability to swallow **OR**
- Inability to remain in an upright position during post oral bisphosphonate administration

We cover Reclast[®] (zoledronic acid) for a documented diagnosis of Paget's disease of the bone (ICD-9 CM 731.0)

Zometa[®] (zoledronic acid)¹

We cover Zometa[®] (zoledronic acid) for a documented diagnosis of any of the following:

- Hypercalcemia of malignancy (ICD-9 CM 275.42)
- Multiple myeloma (ICD-9 CM 203.0)
- Documented bone metastases from solid tumors (ICD-9 CM 198.5)

When services are not covered

We do not cover the above drugs for other conditions not listed above.

Individual consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. For consideration of individual patient, physicians may send relevant clinical information to:

Blue Cross Blue Shield of Massachusetts
Clinical Pharmacy Operations
25 Technology Place
Hingham, MA 02043
Tel: (800) 366-7778
Fax for retail pharmacy authorizations: (800) 583-6289

Managed care guidelines

- Prior authorization is required for all out patient sites of service

Indemnity and PPO guidelines

- Prior authorization **is** required when these medications are processed under the retail pharmacy benefit and home infusion therapy benefit.
- Prior authorization **is not** required when these drugs are purchased by the physician and administered in the office in accordance with this medical policy.

Coding information

Procedure codes are from current CPT, HCPCS Level II, Revenue Code, and/or ICD-9-CM manuals, as recommended by the American Medical Association, Centers for Medicare and Medicaid Services and American Hospital Associations. Blue Cross Blue Shield Association national codes may be developed when appropriate

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

For physicians:

Use HCPCS Level II code J1740, injection, ibandronate, 1 mg. (Boniva)

Use HCPCS Level II code J 3487, Injection, zoledronic acid (Zometa), 1 mg

Use HCPCS Level II code J3488, injection, zoledronic acid, 1 mg. (Reclast)

With diagnosis codes:

- ICD-9 CM 733.00-733.09, osteoporosis (Boniva and Reclast)
- ICD-9 CM 731.0, Paget's disease (Reclast)
- ICD-9 CM 275.42, hypercalcemia of malignancy (Zometa)
- ICD-9 CM 203.00, multiple myeloma (Zometa)
- ICD-9 CM 203.01, multiple myeloma in remission (Zometa)
- ICD-9 CM 203.02, multiple myeloma in relapse (Zometa)
- ICD-9 CM 198.5, documented bone metastases from solid tumors (Zometa)

Policy update history

Policy developed 1/09. Updated 10/09 to reflect UM requirements.

Scientific background, Rationale and References

¹Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 05/13/08.

References:

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This document is designed for informational purposes only and is not an authorization, or an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.

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Request for Outpatient Retail Pharmacy Prior Authorization

Fax to: Clinical Pharmacy Program (800) 583-6289

Phone Authorization (800)366-7778

We plan to respond to your request within two business days of our receipt. To ensure that we can confirm your request (required by NCQA), please be sure to include your fax number.

We cannot process requests unless they contain all of the information requested below:	
Patient Information (REQUIRED)	
Name	
BCBSMA ID Number	
Is the patient a BCBSMA employee? If yes, please fax request to: (617) 246-4013	Yes No
Date of Birth	
Patient's Diagnosis or ICD-9-CM code	
Physician Information (REQUIRED)	
Name	
Medical Specialty	
BCBSMA Provider number/NPI number	
Telephone Number	
Fax Number	
Contact Name (if different from physician)	
Please select one of the three following sections to complete, depending on the nature of your request for the above-named patient.	
Formulary Exception Request	
Name of non-covered drug you want to prescribe	
Reason for Individual Consideration Request (please check one): <input type="checkbox"/> Treatment failure with the following covered drugs in class <input type="checkbox"/> Documented adverse reaction to the following covered drugs <input type="checkbox"/> Other clinical reason (please specify) _____	
Quality Care Dosing Override Request	
Drug name, strength and quantity requested:	
Clinical reason for override (please specify)	
Outpatient Retail Pharmacy Prior Authorization Request	
Drug name:	
Start/End date (must be one year or less):	
Associated Co-morbid diagnosis:	
For Epogen®/Procrit® only:	GFR: _____
	Is patient certified ESRD with Medicare? Yes No
MD Signature:	Date: _____



Outpatient Medical Prior Authorization Form

Please complete and fax to: (888) 641-5355

Please contact Pharmacy Operations with questions at (800) 366-7778

If the patient is a BCBSMA employee, please fax the form to: (617) 246-4013

Servicing Provider	Name: NPI Number:	Requesting Provider	Name: NPI Number:
Phone#		Phone#	
Fax#		Fax#	
Contact Person:		Contact Person:	
Patient Name:		DOB ___/___/___	Diagnosis:
Patient BCBSMA ID#			

Drug/Therapy:

Drug Name: _____ Dates of Service: ___/___/___ to ___/___/___

Dose: _____

Frequency: _____

Additional Clinical (including previous treatment failure):

Physician signature: _____ Date: _____