

Clinical Policy: Ibandronate Oral (Boniva[®])

Reference Number: CP.PMN.96

Effective Date: 03.01.18

Last Review Date: 02.18

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Ibandronate (Boniva[®]) is an oral bisphosphonate.

FDA Approved indication(s)

Boniva is indicated for the treatment and prevention of postmenopausal osteoporosis.

Limitation of use: The optimal duration of use for bisphosphonates has not been determined. The safety and effectiveness of bisphosphonates for the treatment of osteoporosis are based on clinical data of one to four years duration. All patients on bisphosphonate therapy should have the need for continued therapy re-evaluated on a periodic basis. Patients at low-risk for fracture should be considered for drug discontinuation after 3 to 5 years of use. Patients who discontinue therapy should have their risk for fracture re-evaluated periodically.

Policy/Criteria

Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that oral Boniva is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

1. Osteoporosis (must meet all):

1. Prescribed for the prophylaxis or treatment of osteoporosis;
2. Age \geq 18 years;
3. Failure of alendronate at up to maximum indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 150 mg/month (1 tablet/month).

Approval duration: 12 months

2. Other diagnoses/indications

Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Osteoporosis (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy;
3. If request is for a dose increase, dose does not exceed 150 mg/month (1 tablet/month).

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

MO: male osteoporosis

PMO: postmenopausal osteoporosis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug	Dosing Regimen	Dose Limit/ Maximum Dose
alendronate (Fosamax®)	PMO/MO treatment: 10 mg PO QD or 70 mg PO once weekly PMO Prevention: 5mg PO QD or 35 mg PO once weekly Paget's disease: 40 mg PO QD for 6 months	40 mg/day 70 mg/week

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Ibandronate (Boniva)	150 mg orally once monthly on the same day each month	150 mg/month

VI. Product Availability

Tablet: 150mg

VII. References

1. Boniva Prescribing Information. South San Francisco, CA: Genentech USA, Inc. October 2015. Available at <https://www.gene.com/>. Accessed December 2017.
2. Camacho PM, Petak SM, Brinkley N et al. AACE/ACE Guidelines- American Association of Clinical Endocrinologists and American College of Endocrinology Clinical Practice Guidelines for Diagnosis and Treatment of Postmenopausal Osteoporosis. Endocrine Practice Vol 22 (suppl 4) September 2016.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created -Split from CP.PMN.43 – oral bisphosphonates. -No significant changes from previous corporate approved policy. -References reviewed and updated.	12.01.17	02.18

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise

professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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