MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy
Bisphosphonate, Oral

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Policy Number: 058

BCBSA Reference Number: None

Related Policies

- Quality Care Dosing guidelines apply to the following medications and can be found in Medical Policy #621A

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary status of the medications affected by this policy.

Drug	Formulary Information Standard Formulary Status
STEP 1	
alendronate	Covered
alendronate oral solution	
ibandronate	
risedronate	
risedronate DR	
STEP 2	
Actonel® (risedronate)	Prior use of Step 1 Required
STEP 3	

Atelvia™* (risedronate)	Prior use of Step 1 and Step 2 required
Binosto™* (alendronate)	
Boniva®* (ibandronate)	
Fosamax® **tablets*** (alendronate)	
Fosamax ® **Plus D** (alendronate / cholecalciferol)	

*Non formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and step criteria below are met.

We cover the oral bisphosphonate medications listed in the chart above for new starts* in the following stepped approach[1].

*New start is defined as no previous paid claim for the requested medication within the past 130 days.

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications may be covered when **one** of the following criteria is met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 drug within the previous 130 days.

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 2 drug within the previous 130 days.

Step 3: Step 3 medications may be covered when **one** of the following criteria is met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 drug and step 2 drug within the previous 130 days.

OR

- There must be evidence of a BCBSMA paid claim by the patient of a step 3 drug within the previous 130 days. If the Medication is Not Covered/Non-formulary the drug needs to meet requirements for a Formulary Exception for continued coverage.

**Requests based exclusively on the use of samples will not meet coverage criteria for exception. Additional clinical information demonstrating medical necessity of the desired medication must be submitted by the requesting prescriber for review.

We do not cover drugs listed in the above chart when the above step therapy criteria are not met.

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. Physicians may send relevant clinical information for individual patients for consideration to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Tel: 1-800-366-7778
Fax: 1-800-583-6289

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	Action
9/2019	Updated to revise Step Criteria.
6/2017	Updated address for Pharmacy Operations.
1/2016	Updated to add Risedronate DR & Risedronate to step1.
1/2014	Updated ExpressPAth language and remove Blue Value.
9/2012	Updated 9/2012 to remove Actonel Plus Calcium.
8/2012	Updated to add ibandronate to Step 1 and coverage criteria for the new FDA approved medication Binosto™.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
3/2011	Updated to include coverage criteria for new FDA approved medication Atelvia™.
2/2010	Updated to include formulary status change and Express PA info.
9/2009	Policy updated to change 180 day look back period to 130 days and to remove Medicare Part D criteria from Medical Policy.
9/1/2008	New policy, effective 9/1/2008, describing covered and non-covered indications.

References

1. Actonel® [package insert]. Cincinnati, OH: Procter & Gamble Pharmaceuticals; 2008.
2. Boniva® [package insert]. Nutley, NJ: Roche Pharmaceuticals; 2006.
3. Fosamax® [package insert]. Whitehouse Station, NJ: Merck & Co.; 2008.
4. Atelvia™ [package insert]. North Norwich, NY: Norwich Pharmaceuticals, Inc. 2011.

Endnotes

1. Based on the recommendations of the BCBSMA Pharmacy and Therapeutics Committee meeting on 5/13/2008.

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf