Clinical Policy Title:	denosumab
Policy Number:	RxA.313
Drug(s) Applied:	Prolia®
Original Policy Date:	02/07/2020
Last Review Date:	11/30/2023
Line of Business Policy Applies to:	All lines of Business (except Medicare)

Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria. The provision of provider samples does not guarantee coverage under the terms of the pharmacy benefit administered by RxAdvance. All criteria for initial approval must be met in order to obtain coverage.

I. Initial Approval Criteria

A. Osteoporosis (must meet all)**:**

1. Request is for Prolia®;
2. Diagnosis of postmenopausal osteoporosis (PMO), glucocorticoid-induced osteoporosis (GIO), or male osteoporosis and one of the following (a or b):
   a. Member is at high risk for fracture (i ,ii or iii):
      i. BMD T-score at hip or spine ≤ -3.0;
      ii. BMD T-score at hip or spine ≤ -2.5 and major osteoporotic fracture (i.e., hip, spine, forearm, wrist, humerus);
      iii. Recent osteoporotic fracture (within the past 12 months);
   b. Trial and failure of a 3-year trial of bisphosphonate* (alendronate is preferred), unless one of the following (i-v):
      i. All bisphosphonates are contraindicated;
      ii. Clinically significant adverse effects are experienced to both oral and intravenous formulations;
      iii. Member has experienced a loss of BMD while receiving bisphosphonate therapy;
      iv. Member experienced an osteoporotic fracture or fragility fracture while receiving bisphosphonate therapy;
      *Prior authorization may be required for bisphosphonates;
3. Age ≥ 18 years or documentation of closed epiphyses;
4. Prolia® is prescribed by or in consultation with one of the following specialists: a gynecologist, endocrinologist, rheumatologist, geriatrician, orthopaedist, or physiatrist;

Approval duration
Commercial: 12 months
Medicaid: 12 months

B. Prostate or Breast Cancer Treatment-Induced Bone Loss (must meet all)**:**

1. Request is for Prolia®;
2. Diagnosis of one of the following (a or b):

a. Female with breast cancer receiving adjuvant aromatase inhibitor therapy [i.e., anastrozole (Arimidex®), exemestane (Aromasin®) or letrozole (Femara®)];
b. Male with nonmetastatic prostate cancer receiving androgen deprivation therapy [i.e., leuprolide (Lupron®), bicalutamide (Casodex®) or nilutamide (Nilandron®)];

3. Trial and failure of zoledronic acid* (prostate or breast cancer) or pamidronate* (breast cancer) at up to maximally indicated doses unless both are contraindicated, or clinically significant adverse effects are experienced;
   *Prior authorization may be required
4. Prescribed by or in consultation with an oncologist;
5. Age ≥ 18 years or documentation of closed epiphyses;

Approval duration
Commercial: 12 months
Medicaid: 12 months

II. Continued Therapy Approval

A. All Indications in Section I (must meet all)**:**

1. Member is current receiving or has been treated with this medication within the past 90 days, excluding manufacturer samples.

Approval duration
Commercial: 12 months
Medicaid: 12 months

References

1. Gralow JR, Biermann JS, Farooki A, et al. Nccn task force report: bone health in cancer care. Journal of the National Comprehensive Cancer Network. 2009;7(Suppl_3) :S-S-32. Available at: https://jnccn.org/view/journals/jnccn/7/Suppl_3/article-pS-1.xml. Accessed October 18, 2022.
2. Cosman F, de Beur SJ, LeBoff MS, et al. Clinician's guide to prevention and treatment of osteoporosis. Osteoporos Int. 2014;25(10):2359-2381. Available at: https://link.springer.com/article/10.1007/s00198-014-2794-2. Accessed October 18, 2022.
3. Camacho PM, Petak SM, Binkley N, et al. American association of clinical endocrinologists/american college of endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis—2020 update. Endocrine Practice. 2020; 26:1-46. Available at: https://www.endocrinepractice.org/article/S1530-891X(20)42827-7/fulltext. Accessed October 18, 2022.
4. Watts NB, Adler RA, Bilezikian JP, et al. Osteoporosis in men: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2012; 97(6): 1802-1822. Available at: https://pubmed.ncbi.nlm.nih.gov/22675062/. Accessed October 18, 2022.
5. Buckley L, Guyatt G, Fink HA, et al. 2017 American college of rheumatology guideline for the prevention and treatment of glucocorticoid-induced osteoporosis: ACR guideline for glucocorticoid-induced osteoporosis prevention and treatment. Arthritis & Rheumatology. 2017;69(8):1521-1537. Available at: https://pubmed.ncbi.nlm.nih.gov/28585373/. Accessed October 18, 2022.
6. Sozen T, Ozisik L, Basaran NC. An overview and management of osteoporosis. Eur J Rheumatol. 2017;4(1):46-56. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5335887/. Accessed October 18, 2022.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed:	07/31/2020	09/14/2020

1. Policy title table was updated. 2. Line of Business Policy Applies to was update to "All lines of business". 3. Initial approval duration for all indications was updated to 6 months, and continued approval duration was updated to 12 months. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance..." 5. APPENDIX D: General Information added. 6. References were updated.		
Policy was reviewed: 1. Osteoporosis: Initial criteria I.A.4 was updated. 2. Initial approval duration was updated to 12 months. 3. Approval criteria for systemic mastocytosis and other NCCN recommended off-label indications were added. 4. References were reviewed and updated	01/19/2021	03/09/2021
Policy was reviewed: 1. Dosing Information, Maximum Dose, Xgeva®: Updated to maximum dosing information from 20 mg/dose to 120 mg/dose for indication Multiple myeloma and bone metastasis from solid tumors. 2. Statement about provider sample ''The provision of provider samples does not guarantee coverage…" was added to Clinical Policy. 3. Initial Approval Criteria I.A 2.a.ii updated from BMD T-score at hip or spine ≤ -3.5 to BMD T-score at hip or spine ≤ -3.0. 4. Initial Approval Criteria: Updated a. I.B.2.b: Updated trial and failure criteria from Nilandron® to nilutamide (Nilandron®). b. I.D.4: Updated to include new trial and failure criteria Member not responding to bisphosphonates or for patients who are not candidates for bisphosphonates because of renal insufficiency. 5. Appendix B: Updated a. Drug Name: Updated to remove unavailable generic therapeutic alternative alendronate/ cholecalciferol. b. Statement about drug listing format in Appendix B is rephrased to "Therapeutic	11/29/2021	01/17/2021

alternatives are listed as generic (Brand name®) when the drug is available by both generic and brand; Brand name® when the drug is available by brand only and generic name when the drug is available by generic only". 6. Disclaimer about contraindications," Contraindications listed reflect statements made in the manufacturer's package insert.." was added to Appendix C. 7. References were reviewed and updated.		
Policy was reviewed: 1. Initial Approval Criteria, I.A.2.a.iii: Updated to include new dosing criteria Recent osteoporotic fracture (within the past 12 months). 2. Initial Approval Criteria, I.A.2.b: Updated trial and failure criteria from Failure of a 12-month trial of an oral bisphosphonate (alendronate is preferred) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced to Trial and failure of a 3-year trial of bisphosphonate (alendronate is preferred) , unless one of the following (i-v): i. All bisphosphonates are contraindicated; ii. Clinically significant adverse effects are experienced to both oral and intravenous formulations; iii. Member has experienced a loss of BMD while receiving bisphosphonate therapy; iv. Member experienced an osteoporotic fracture or fragility fracture while receiving bisphosphonate therapy. 3. Initial Approval Criteria, I.B.3: Updated to include new trial and failure criteria Trial and failure of zoledronic acid* (prostate or breast cancer) or pamidronate* (breast cancer) at up to maximally indicated doses unless both are contraindicated, or clinically significant adverse effects are experienced. *Prior authorization may be required. 4. Updated Multiple Myeloma or Solid tumour, Giant Cell Tumor of Bone and Hypercalcemia of Malignancy criteria to form separate criteria for each indication as I.C, I.D. and I.E. 5. Initial Approval Criteria, I.F.8: Updated dosing criteria from Dose is supported by peer-	10/18/2022	01/17/2023

reviewed literature (prescriber must submit supporting evidence) to Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence) *Prescribed regimen must be FDA-approved or recommended by NCCN. 6. Initial Approval Criteria, I.G.6: Updated dosing criteria from Dose is within FDA maximum limit for any FDA-approved indication or is supported by peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence to Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence) *Prescribed regimen must be FDA-approved or recommended by NCCN. 7. Continued Therapy Approval Criteria, II.A.3.b: Updated dosing criteria from Xgeva®: 120 mg every 4 weeks to Xgeva®: 120 mg every 4 weeks or is supported by practice guidelines or peer reviewed literature for the relevant off-label use (prescriber must submit supporting evidence) *Prescribed regimen must be FDA-approved or recommended by NCCN. 8. Appendix D, General Information: Updated to include new information IV/PO Bisphosphonates: Examples of Contraindications and Adverse Effects. 9. References were reviewed and updated.		
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed. 1. Removed Xgeva from policy. 2. Removed dosing criteria. 3. Removed restrictions on concurrent prescribing. 4. Removed reauthorization requirement for positive response to therapy.	12/14/2023	11/30/2023