

## **Clinical Policy: Alendronate (Binosto, Fosamax Plus D)**

Reference Number: CP.PMN.88

Effective Date: 03.01.18

Last Review Date: 02.20

Line of Business: Commercial, HIM\*, Medicaid

[Revision Log](#)

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

### **Description**

Alendronate sodium effervescent tablets (Binosto<sup>®</sup>), and alendronate/cholecalciferol (Fosamax Plus D<sup>®</sup>) are oral bisphosphonates.

*\*For Health Insurance Marketplace (HIM), Binosto is non-formulary and should not be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.*

### **FDA Approved Indication(s)**

Binosto and Fosamax Plus D are indicated for:

- Postmenopausal osteoporosis (PMO): Treatment of osteoporosis in postmenopausal women.
- Male osteoporosis: Treatment to increase bone mass in men with osteoporosis.

Limitation(s) of use:

- Fosamax Plus D alone should not be used to treat vitamin D deficiency.
- 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 (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<sup>®</sup> that Binosto and Fosamax Plus D are **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

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

1. Diagnosis of PMO or male osteoporosis;
2. Age  $\geq$  18 years or documentation of closed epiphyses on x-ray;
3. Failure of a 12-month trial of alendronate at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 1 tablet per week (Binosto: 70 mg per week; Fosamax Plus D: 70 mg/5600 IU per week).

##### **Approval duration:**

**Medicaid/HIM** – 12 months  
**Commercial** – Length of Benefit

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace.

**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, new dose does not exceed 1 tablet per week (Binosto: 70 mg per week; Fosamax Plus D: 70 mg/5600 IU per week).

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – Length of Benefit

**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 the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace.

**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 policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

BMD: bone mineral density

GIO: glucocorticoid-induced osteoporosis

FDA: Food and Drug Administration

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 and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
alendronate (Fosamax <sup>®</sup> )	<ul style="list-style-type: none"> <li>Treatment: PMO, male osteoporosis 10 mg PO QD or 70 mg PO once weekly</li> <li>Prevention: PMO 5 mg PO QD or 35 mg PO once weekly</li> </ul>	40 mg/day 70 mg/week

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

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): abnormalities of the esophagus which delay esophageal emptying such as stricture or achalasia; inability to stand/sit upright for at least 30 minutes; hypocalcemia; hypersensitivity; increased risk of aspiration (Binosto only)
- Boxed warning(s): none reported

**V. Dosage and Administration**

Drug Name	Indication	Dosing Regimen	Maximum Dose
Alendronate effervescent (Binosto)	Treatment: PMO, male osteoporosis	70 mg PO once weekly	70 mg/week
Alendronate/cholecalciferol (Fosamax Plus D)		70 mg alendronate /2800 IU vitamin D3 or 70 mg alendronate /5600 IU vitamin D3 PO once weekly	70 mg / 5600 IU/ week

**VI. Product Availability**

Drug Name	Availability
Alendronate effervescent (Binosto)	Effervescent tablet: 70 mg
Alendronate/cholecalciferol (Fosamax Plus D)	Tablet: 70 mg/2800 IU, 70 mg/5600 IU

**VII. References**

- Fosamax Plus D Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc; August 2019. Available at: [https://www.merck.com/product/usa/pi\\_circulars/f/fosamax/fosamax\\_pi.pdf](https://www.merck.com/product/usa/pi_circulars/f/fosamax/fosamax_pi.pdf). Accessed October 22, 2019.
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Guidelines for Diagnosis and Treatment of Postmenopausal Osteoporosis. Endocrine Practice Vol 22 (suppl 4) September 2016.

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8. Hodsman AB, Bauder DC, Dempster DW, et al. Parathyroid hormone and teriparatide for the treatment of osteoporosis: a review of the evidence and suggested guidelines for its use. Endocr Rev. 2005 Aug;26(5):688-703. Epub 2005 Mar 15.

Male Osteoporosis

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created Split from HIM.PA.51 and CP.CPA.212 – oral bisphosphonates. Combined policy for marketplace and commercial lines of business No significant changes from previous corporate approved policy. References reviewed and updated.	12.01.17	02.18
1Q 2019 annual review: no significant changes; modified failure language to require medical justification as the request would be for a product with the same active ingredient; references reviewed and updated	11.05.18	02.19
1Q 2020 annual review: added Medicaid line of business; age or closed epiphyses added; references reviewed and updated.	11.19.19	02.20

**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

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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.

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