Clinical Policy: Ibandronate Injection (Boniva)
Reference Number: CP.PHAR.189
Effective Date: 11.15.17
Last Review Date: 02.21
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Ibandronate injection (Boniva®) is a bisphosphonate.

FDA Approved Indication(s)
Boniva is indicated for:
- Postmenopausal osteoporosis (PMO): Treatment of osteoporosis in postmenopausal women. In postmenopausal women with osteoporosis, Boniva increases bone mineral density (BMD) and reduces the incidence of vertebral fractures.

Limitation(s) of use: Optimal duration of use has not been determined. For patients at low-risk for fracture, consider drug discontinuation after 3 to 5 years of use.

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® that Boniva injection is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Osteoporosis (must meet all):
      1. Diagnosis of PMO;
      2. Age ≥ 18 years or documentation of closed epiphyses on x-ray;
      3. Failure of a 12-month oral bisphosphonate* trial (Appendix B; alendronate is preferred) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
         *Prior authorization may be required.
      4. Dose does not exceed 3 mg (1 syringe) every 3 months.
   Approval duration:
   Medicaid/HIM – 6 months
   Commercial – 6 months or to the member’s renewal date, whichever is longer

   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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.
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 3 mg (1 syringe) every 3 months.

      Approval duration:
      Medicaid/HIM – 12 months
      Commercial – 6 months or to the member’s renewal date, whichever is longer

   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 6 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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

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.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   BMD: bone mineral density
   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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral bisphosphonates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>alendronate (Fosamax®)</td>
<td>Treatment/prevention: PMO</td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>Treatment: GIO, male osteoporosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment: Paget disease</td>
<td></td>
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<tr>
<td></td>
<td>See prescribing information for dose.</td>
<td></td>
</tr>
</tbody>
</table>
### Drug Name

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
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</thead>
</table>
| Fosamax® Plus D (alendronate / cholecalciferol) | Treatment: PMO, male osteoporosis  
See prescribing information for dose. |                         |
| risedronate (Actonel®, Atelvia®) | Actonel: Treatment/prevention: PMO, GIO  
Treatment: male osteoporosis  
Treatment: Paget disease  
Atelvia: Treatment: PMO  
See prescribing information for dose. |                         |
| ibandronate (Boniva®)           | Treatment/prevention: PMO  
See prescribing information for dose. |                         |

**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.**

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### Appendix C: Contraindications/Boxed Warnings
- Contraindication(s): hypocalcemia, hypersensitivity
- Boxed warning(s): none reported

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### V. Dosage and Administration

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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMO</td>
<td>3 mg IV every 3 months</td>
<td>3 mg/3 months</td>
</tr>
</tbody>
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### VI. Product Availability

Single-use prefilled syringe: 3 mg/3 mL

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### VII. References


Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>J1740</td>
<td>Injection, ibandronate sodium, 1 mg</td>
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Reviews, Revisions, and Approvals

<table>
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<tr>
<th>Date</th>
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Removed age restriction. Added “at total hip” to T score. Added that osteoporotic fracture should be confirmed by radiographic imaging.

Certain conditions representing potential contraindications to therapy and other safety criteria removed. Removed requirement for administration of calcium/vitamin D if dietary intake is inadequate. Added dose to continued therapy. Added requirement for positive response to therapy

1Q18 annual review: policies combined for commercial and Medicaid; removed criteria for evidence of diagnosis; modified trial and failure requirements to an oral bisphosphonate and removed definition of treatment failure; removed requirement regarding admin of last dose of Reclast; removed hypocalcemia monitoring requirement; references reviewed and updated. 11.15.17 02.18

1Q 2019 annual review: added HIM line of business; added age requirement; revised commercial approval duration to “6 months or to the member’s renewal date, whichever is longer”; added HCPCS code information; references reviewed and updated. 11.01.18 02.19

1Q20 annual review: removed HIM disclaimer for HIM NF drugs; age - added closed epiphyses if younger than 18; references reviewed and updated. 11.19.19 02.20

1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated. 10.26.20 02.21
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.

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and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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