

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

[Coding Implications](#)

[Revision Log](#)

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 \geq 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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Oral bisphosphonates</i>		
alendronate (Fosamax [®])	Treatment/prevention: PMO Treatment: GIO, male osteoporosis Treatment: Paget disease <i>See prescribing information for dose.</i>	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Fosamax [®] Plus D (alendronate / cholecalciferol)	Treatment: PMO, male osteoporosis <i>See prescribing information for dose.</i>	
risedronate (Actonel [®] , Atelvia [®])	Actonel: Treatment/prevention: PMO, GIO Treatment: male osteoporosis Treatment: Paget disease Atelvia: Treatment: PMO <i>See prescribing information for dose.</i>	
ibandronate (Boniva [®])	Treatment/prevention: PMO <i>See prescribing information for dose.</i>	

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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypocalcemia, hypersensitivity
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PMO	3 mg IV every 3 months	3 mg/3 months

VI. Product Availability

Single-use prefilled syringe: 3 mg/3 mL

VII. References

1. Boniva Injection Prescribing Information. South San Francisco, CA: Genentech USA, Inc.; April 2019. Available at <https://www.gene.com>. Accessed October 26, 2020.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2020. URL: <http://www.clinicalpharmacology.com>.

Osteoporosis Diagnosis, Fracture Risk, and Treatment

3. Shoback D, Rosen CJ, Black DM, et al. Pharmacological management of osteoporosis in postmenopausal women: an endocrine society guideline update. J Clin Endocrinol Metab; March 2020, 105(3): 587-594.
4. Eastell R, Rosen CJ, Black DM, et al. Pharmacological management of osteoporosis in postmenopausal women: An Endocrine Society Clinical Practice Guideline. J Clin Endocrinol Metab; 2019, 104: 1595–1622.
5. 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.

6. National Osteoporosis Foundation Clinician’s Guide to Prevention and Treatment of Osteoporosis. Osteoporosis International 2014. Available at: <http://nof.org/files/nof/public/content/file/2791/upload/919.pdf>. Accessed October 31, 2018.
7. Siris ES, Adler R, Bilezikian J, et al. The clinical diagnosis of osteoporosis: a position statement from the National Bone Health Alliance Working Group. *Osteoporos Int* (2014) 25:1439–1443. DOI 10.1007/s00198-014-2655-z.
8. Hodsmen 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.

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.

HCPCS Codes	Description
J1740	Injection, ibandronate sodium, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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	03.17	03.17
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.

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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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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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