

Clinical Policy: Etidronate (Didronel)

Reference Number: CP.PMN.94

Effective Date:03.01.18

Last Review Date: 02.21

Line of Business: Medicaid

[Revision Log](#)

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

Description

Etidronate (Didronel[®]) is an oral bisphosphonate.

FDA Approved Indication(s)

Didronel is indicated for:

- Paget disease: Treatment of symptomatic Paget's disease of bone
- Heterotopic ossification (HO): Prevention and treatment of HO following total hip replacement or due to spinal cord injury.

Limitation(s) of use: Etidronate is not approved for the treatment of osteoporosis.

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 Didronel is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Paget's Disease (must meet all):

1. Diagnosis of Paget's disease of the bone;
2. Age \geq 18 years or documentation of closed epiphyses on x-ray;
3. Failure of \geq 6 month trial of alendronate at maximum indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 20 mg/kg per day.

Approval duration: 6 months (doses \leq 10 mg/kg/day); **3 months** (doses $>$ 10 mg/kg/day)

B. Heterotopic Ossification (must meet all):

1. Diagnosis of or increase risk of heterotopic ossification due to (a or b):
 - a. Spinal cord injury;
 - b. Total hip replacement;
2. Age \geq 18 years or documentation of closed epiphyses on x-ray;
3. Dose does not exceed 20 mg/kg per day.

Approval duration: 3 months (spinal cord injury); **4 months** (hip replacement)

C. Hypercalcemia of Malignancy (off-label) (must meet all):

1. Diagnosis of hypercalcemia of malignancy;
2. Prescribed by or in consultation with an oncologist;
3. Age \geq 18 years or documentation of closed epiphyses on x-ray;
4. Dose does not exceed 20 mg/kg per day.

Approval duration: 3 months

D. 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.PMN.53 for Medicaid.

II. Continued Therapy

A. Paget's Disease (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. At least 3 months have elapsed since the completion of previous therapy with Didronel;
3. If request is for a dose increase, new dose does not exceed 20 mg/kg per day.

Approval duration: 6 months (doses \leq 10 mg/kg/day); **3 months** (doses $>$ 10 mg/kg/day)

B. Heterotopic Ossification (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has NOT received (a or b):
 - a. \geq 3 months of treatment if spinal cord injury;
 - b. \geq 4 months of treatment if hip replacement;
3. Member is responding positively to therapy;
4. If request is for a dose increase, dose does not exceed 20 mg/kg per day.

Approval duration: 3 months TOTAL (for spinal cord injury); **4 months TOTAL** (hip replacement)

C. Hypercalcemia of Malignancy (off-label) (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria.
2. Member has not received \geq 90 days of therapy;
3. Member is responding positively to therapy;
4. If request is for a dose increase, dose does not exceed 20 mg/kg per day.

Approval duration: 3 months TOTAL

D. 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.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 policy - CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration

HO: heterotopic ossification

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
alendronate (Fosamax [®])	Paget's disease: 40 mg PO QD for 6 months	40 mg/day

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): abnormalities of the esophagus which delay esophageal emptying such as stricture or achalasia; hypersensitivity
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Paget's disease	5 to 10 mg/kg/day, not to exceed 6 months or 11 to 20 mg/kg/day, not to exceed 3 months	20 mg/kg/day
HO	- Total hip replacement: 20 mg/kg/day for 1 month before and 3 months after surgery (4 months total) - Spinal cord-injured: 20 mg/kg/day for 2 weeks then 10 mg/kg/day for 10 weeks (12 weeks total)	20 mg/kg/day

VI. Product Availability

Tablets: 200 mg, 400 mg

VII. References

1. Didronel Prescribing Information. Morgantown, WV: Mylan Pharmaceuticals Inc. April 2015. Available at https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/017831s058lbl.pdf. Accessed October 26, 2020.

2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2020. URL: <http://www.clinicalpharmacology.com>.

Paget Disease

3. Singer FR, Bone HG, Hosking DJ, et al. Paget’s disease of the bone: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2014; 99(12): 4480-4422.

Reviews, Revisions, and Approvals	Date	P & T Approval Date
New policy created Split from CP.PMN.43 – oral bisphosphonates. No significant changes from previous corporate approved policy. References reviewed and updated.	12.01.17	02.18
1Q 2019 annual review: for Paget’s disease – removed alkaline phosphate requirement, revised initial approval duration to 3 or 6 months based on requested dose, modified response criteria to “Disease has relapsed or progressed (e.g., increases in or failure to achieve normalization of serum ALP, radiographic progression of disease)”; for hypercalcemia of malignancy modified approval duration to 3 months, clarified in continued approval for maximum 3 months of total treatment; references reviewed and updated.	11.01.18	02.19
1Q 2020 annual review: age added for all indications; Paget disease: continuation of therapy requirements removed for individualization of therapy; HO: use expanded to prevention; hypercalcemia of malignancy: oncologist added, continuation of therapy requirements removed given response fluidity; references reviewed and updated.	11.19.19	02.20
1Q 2021 annual review: no significant changes; 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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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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