Clinical Policy: Alendronate (Binosto, Fosamax Plus D)

Reference Number: DE.PMN.88
Effective Date: 01.23
Last Review Date: 01.23
Line of Business: Medicaid

Revision Log

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

Description

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

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***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:

- Binosto and Fosamax Plus D: 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.
- Fosamax Plus D alone should not be used to treat vitamin D deficiency.

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 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 ≥ 18 years or documentation of closed epiphyses on x-ray;
3. Failure of an adequate trial of at least two preferred* FDA-approved drugs for the indication and/or drugs that are considered the standard of care within the same drug class on the PDL, when such agents exist, at maximum indicated doses, unless clinically significant adverse effect are experienced, or all are contraindicated;
   **Generic is preferred, if available, and brand is not the preferred agent*
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 – 12 months

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.PMN.53.

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 – 12 months

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.PMN.53.

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.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

BMD: bone mineral density
FDA: Food and Drug Administration
GIO: glucocorticoid-induced osteoporosis
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®)	• Treatment: PMO, male osteoporosis 10 mg PO QD or 70 mg PO once weekly • Prevention: PMO 5 mg PO QD or 35 mg PO once weekly	40 mg/day 70 mg/week

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 emtyping 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

1. Fosamax Plus D Prescribing Information. Whitehouse Station, NJ: Merck & Co., Inc; August 2021. Available at: https://www.organon.com/product/usa/pi_circulars/f/fosamax/fosamax_plus_d_pi.pdf . Accessed September 13, 2021.
2. Binosto Prescribing Information. San Antonio, TX: Mission Pharmacal Company; October 2020. Available at: https://www.binosto.com. Accessed September 13, 2021.
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Osteoporosis Diagnosis, Fracture Risk, and Treatment

4. 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.
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7. National Osteoporosis Foundation Clinician's Guide to Prevention and Treatment of Osteoporosis. Osteoporosis International 2014. Available at: https://cdn.nof.org/wp-content/uploads/2016/01/995.pdf. Accessed September 13, 2021.

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9. 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

10. Watts NB, Adler RA, Bilezikian JP, et al. Osteoporosis in men: an Endocrine Society clinical practice guidelines. J Clin Endocrinol Metab 2012;97(6):1802-1822.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.22	01.23

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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