Clinical Policy: Romosozumab-aqqg (Evenity)

Reference Number: CP.PHAR.428
Effective Date: 05.21.19
Last Review Date: 02.24
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

Romosozumab-aqqg (Evenity®) is a sclerostin inhibitor.

FDA Approved Indication(s)

Evenity is indicated for the treatment of osteoporosis in postmenopausal (PMO) women at high risk for fracture.*

**High risk of fracture is defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.*

Limitation(s) of use: Limit duration of use to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered.

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

I. Initial Approval Criteria

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

1. Diagnosis of PMO and one of the following (a or b):
   a. Member is at very high risk for fracture as evidenced by one of the following (i, ii, or iii):
      i. Recent osteoporotic fracture (within the past 12 months);
      ii. Bone mineral density (BMD) T-score at hip or spine ≤ -3.0;
      iii. BMD T-score at hip or spine ≤ -2.5 AND major osteoporotic fracture (i.e., hip, spine, forearm, wrist, humerus);
   b. Member has completed a 3-year trial of bisphosphonate therapy* *(see Appendix B; generic alendronate is preferred)* at up to maximally indicated doses, unless one of the following (i-v):
      **Prior authorization may be required for bisphosphonates*
      i. All bisphosphonates are contraindicated;
      ii. Clinically significant adverse effects are experienced to both IV and PO formulations (*see Appendix D*)
      iii. Member has experienced a loss of BMD while receiving bisphosphonate therapy;

iv. Member has experienced a lack of BMD increase after ≥ 12 months of bisphosphonate therapy;
v. Member experienced an osteoporotic fracture or fragility fracture while receiving bisphosphonate therapy;

2. Age ≥ 18 years or documentation of closed epiphyses on x-ray;
3. Member has not received ≥ 12 months cumulative romosozumab therapy;
4. Dose does not exceed both of the following (a and b):
   a. 210 mg per month;
   b. 2 prefilled syringes per month.

Approval duration: 6 months (limited to 12 months cumulative romosozumab use lifetime)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. Member has not received ≥ 12 months cumulative romosozumab therapy;
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 210 mg per month;
   b. 2 prefilled syringes per month.

Approval duration: 6 months (limited to 12 months cumulative use lifetime)

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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
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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
IV bisphosphonates		
ibandronate (Boniva)	3 mg IV every 3 months.	3 mg/3 months
zoledronic acid (Reclast®)	5 mg IV once a year	5 mg/year
Oral bisphosphonates		
alendronate (Fosamax®)	10 mg PO QD or 70 mg PO once	70 mg/week
Fosamax® Plus D (alendronate / cholecalciferol)	70 mg alendronate /2800 IU vitamin D3 or 70 mg alendronate /5600 IU vitamin D3 PO once weekly	70 mg / 5600 IU/ week

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
risedronate (Actonel®, Atelvia®)	Actonel: 5 mg PO QD or 35 mg PO once weekly or 75 mg PO QD taken on two consecutive days each month or 150 mg PO once monthly Atelvia: 35 mg PO once weekly	Actonel: 5 mg/day 35 mg/week 150 mg/month Atelvia: 35 mg/week
ibandronate (Boniva®)	150 mg PO once monthly	150 mg/month

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; known hypersensitivity to Evenity
- Boxed warning(s): potential risk of myocardial infarction, stroke, cardiovascular death

Appendix D: IV/PO Bisphosphonates: Examples of Contraindications and Adverse Effects

Bisphosphonates	Oral Formulations	IV Formulations
Contraindications		
Hypocalcemia	X	X
Increased risk of aspiration	X	-
Hypersensitivity to product component	X	X
Inability to stand/sit upright for at least 30 minutes	X	-
Creatinine clearance < 35 mL/min or evidence of acute renal impairment	-	X
Esophagus abnormalities which delay emptying such as stricture or achalasia	X	-
Clinically significant warnings or adverse side effects		
Pregnancy	X	X
Eye inflammation	X	X
Acute renal failure	X	X
Osteonecrosis of the jaw	X	X
Atypical femoral shaft fracture	X	X
Drug interactions (product-specific)	X	X
Severe or incapacitating musculoskeletal pain	X	X

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PMO	210 mg (2 prefilled syringes) SC once every month	210 mg/month up to 12 months cumulative use

VI. Product Availability

Prefilled syringe: 105 mg/1.17 mL

VII. References

1. Evenity Prescribing Information. One Amgen Center Drive, Thousand Oaks, CA; Amgen Inc.: April 2020. Available at: https://www.evenityproliahcp.com/. Accessed October 23, 2023.
2. Clinical Pharmacology [database online]. Tampa, FL: Elsevier 2023. Available at: www.clinicalkeys.com/pharmacology.

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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. American Association of Clinical Endocrinologists/American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis-2020 update. *Endocr Pract*. 2020;26(1):1-46.
6. LeBogg MS, Greenspan SL, Insongna KL, et al. Clinician's guide to prevention and treatment of osteoporosis. *Osteoporos Int.* 2022 Oct;33(10):2049-2102. doi:10.1007/s00198-021-05900-y. Erratum in: *Osteoporos Int.* 2022 Jul 28.
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. 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;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
J3111	Injection, romosozumab-aqqg, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2020 annual review: added HIM line of business and removed HIM disclaimer for HIM NF drugs; very high fracture risk or 3-year bisphosphonate trial added with required contraindication to both	11.19.19	02.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
PO/IV formulations; specialists removed; age 18 or closed epiphyses added per PI; references reviewed and updated.		
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; added coding implications; references reviewed and updated.	10.26.20	02.21
1Q 2022 annual review: updated definition of very high risk for fracture per 2020 AACE/ACE PMO treatment guideline; references reviewed and updated.	09.16.21	02.22
Added option (in addition to contraindications or adverse effects) to bypass bisphosphonate trial if member has experienced a loss of BMD, lack of BMD increase, or has had an osteoporotic fracture or fragility fracture while receiving bisphosphonate therapy.	02.07.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.23.22	
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.01.22	02.23
1Q 2024 annual review: added criteria to ensure the member has not received ≥ 12 months cumulative Evenity therapy before approval per PI; clarified failure of "generic" alendronate is preferred; clarified dosage regimen in Appendix B per PI; reference reviewd and updated.	10.23.23	02.24

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members 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.