GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS **BISPHOSPHONATES**

PGST SSB – Ref# 367-D: **Binosto, Fosamax Plus D**

HPGST SSB – Ref# 401-D: **Binosto, Fosamax Plus D**

TGST SSB – Ref# 377-D: **Binosto, Fosamax Plus D**

Status: CVS Caremark Criteria
Type: Initial Step Therapy; Post Step Therapy Prior Authorization

INITIAL STEP THERAPY
If the patient has filled a prescription for at least a 28 day supply of at least one generic bisphosphonate within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the system will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA
Branded bisphosphonates will be covered with post step therapy prior authorization when the following criteria are met:

- Patient has experienced an inadequate treatment response, intolerance, or contraindication to at least one generic bisphosphonate drug.

RATIONALE
If the patient has filled a prescription for at least a 28 day supply of at least one generic bisphosphonate within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit.

If the patient does not meet the initial step therapy criteria, then prior authorization is required.

If the patient has a documented contraindication to or a potential drug interaction with a generic drug, then the requested brand drug will be covered. If the patient is intolerant to at least one of the generic drugs, then the requested brand drug will be covered. If the patient has tried one of the generic drugs for a sufficient trial and had an inadequate treatment response (as determined on most recent DEXA scan), then the requested brand drug will be covered. If these requirements are met, then the approval duration is 24 months.

REFERENCES
N/A

Written by:	UM Development (NB)
Date Written:	11/2008
Revised:	12/2008, 02/2009, 09/2009, 10/2009. 07/2010, 01/2011, 05/2011, 01/2012 (removed Actonel w/ Calcium), 04/2012 (removed Boniva), 07/2012 (removed Atelvia from PGST); 09/2012 (updated formatting and documentation), 10/2012 (added Binosto), 10/2013 (updated grids, re-worded question #2 & #3), 08/2014 (removed Actonel 150mg), 10/2014 (reordered questions, updated format), 07/2015 (removed Actonel and Atelvia), 10/2015, 10/2016 (no changes) , (SF) 10/2017 (no changes)
Reviewed:	Medical Affairs (WF, MD) 12/2008, 02/2009, 09/2009, 10/2009, 07/2010, 01/2011, 01/2012, 04/2012, 07/2012; (DC) 09/2012, (LB) 10/2012, (LS) 10/2013, (DC) 08/2014, (SS) 10/2014, 07/2015
External Review:	01/2009, 12/2009, 02/2011, 02/2012, 02/2013, 02/2014, 02/2015, 02/2016, 02/2017, 02/2018

CRITERIA FOR APPROVAL

1	Has the patient demonstrated an inadequate treatment response (as determined on most	Yes	No

	recent DEXA scan) after a sufficient trial of a generic bisphosphonate? [If yes, then no further questions.]		
2	Does the patient have a documented contraindication to or a potential drug interaction with a generic bisphosphonate? [If yes, then no further questions.]	Yes	No
3	Has the patient had a trial and was intolerant to at least one generic bisphosphonate?	Yes	No

Guidelines for Approval					
Duration of Approval			**24 Months**		
Set 1 - Failed Trial		**Set 2 – Contraindication**		**Set 3 – Intolerant**	
Yes to question(s)	**No to question(s)**	**Yes to question(s)**	**No to question(s)**	**Yes to question(s)**	**No to question(s)**
1	None	2	1	3	1
					2

Mapping Instructions		
	Yes	**No**
1	Approve for 24 months	Go to 2
2	Approve for 24 months	Go to 3
3	Approve for 24 months	Deny