

**EFFECTIVE DATE:** 12|01|2019

**POLICY LAST UPDATED:** 08|06|2019

## OVERVIEW

Evenity™ (romosozumab-aqqg) is indicated for the treatment of osteoporosis in postmenopausal women at high risk for fracture 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.

This policy is applicable to BlueCHiP for Medicare products only. For Commercial Products, see related policy section.

## MEDICAL CRITERIA

### Initial Evaluation

Evenity™ (romosozumab-aqqg) will be approved when ALL of the following are met:

1. BOTH of the following:
    - a. The patient is a postmenopausal female OR the prescriber has provided documentation that the requested agent is medically appropriate for the patient's gender

**AND**

    - b. The patient has a diagnosis of osteoporosis defined as ONE of the following:
      - i. The patient has a history of vertebral fracture(s), or low trauma or fragility fracture(s) (e.g., prior fracture from minor trauma such as falling from standing height or less) within the past 5 years

**OR**

      - ii. BOTH of the following:
        - A. The patient has a T-score at or below -2.5

**AND**

        - B. ONE of the following:
          - i. The patient has tried and had an inadequate response to a bisphosphonate (12 month minimum treatment with evidence of no BMD improvement)

**OR**

          - ii. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to both an oral and IV bisphosphonate
  2. One of the following:
    - a. Patient had an inadequate response to denosumab or parathyroid hormone/analog (12 month minimum treatment with evidence of no BMD improvement)

**OR**

    - b. Patient has a documented intolerance, FDA labeled contraindication(s), or hypersensitivity to denosumab or parathyroid hormone/analog that is not expected to occur with Evenity (romosozumab-aqqg)
  3. The patient does not have any FDA labeled contraindications to the requested agent
- AND**
4. ONE of the following:
    - a. The requested quantity (dose) is less than or equal to the program limit

**OR**

- b. ALL of the following:
  - i. The requested quantity (dose) is greater than the program quantity limit  
**AND**
  - ii. The requested quantity (dose) does not exceed the maximum FDA labeled dose  
**AND**
  - iii. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit

**AND**

- 5. The total duration of treatment with Evenity (romosozumab-aqqg) has not exceeded 12 months in lifetime

**Length of Approval:** Up to a total of 12 months of treatment per lifetime

**PRIOR AUTHORIZATION**

Prior authorization is required for BlueCHiP for Medicare.

**POLICY STATEMENT**

**BlueCHiP for Medicare**

Evenity™ (romosozumab-aqqg) is medically necessary when the criteria above have been met.

**COVERAGE**

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable physician administered drug benefits/coverage.

**BACKGROUND**

**Postmenopausal Osteoporosis**

The diagnosis of osteoporosis (OP) in postmenopausal women over the age of 50 can be established through one of the following:

- Presence of fragility fractures (hip or spine) in the absence of other metabolic bone disorders
- T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip
- T-score between -1 and -2.5 and increased risk using FRAX country-specific thresholds<sup>2</sup>
- T-score between -1 and -2.5 with a fragility fracture of the proximal humerus, pelvis, or possibly distal forearm

Definitions of bone density

Normal	T-score $\geq$ -1.0
Low bone mass (osteopenia)	T-score between -1.0 and -2.5
Osteoporosis	T-score $\leq$ -2.5

The North American Menopause Society (NAMS) and National Osteoporosis Foundation (NOF) as well as the American Association of Clinical Endocrinologists (AACE) recommend adding OP drug therapy in the following populations:

- All postmenopausal women who have had an osteoporotic vertebral or hip fracture
- All postmenopausal women who have BMD values consistent with OP (i.e., T-scores < -2.5) at the lumbar spine, femoral neck, or total hip region.
- All postmenopausal women who have T-scores from -1.0 to -2.5 at the femoral neck or spine and a 10-year probability of a hip fracture  $\geq$  3% or a 10-year probability of a major OP-related fracture  $\geq$  20% based on the U.S.-adapted WHO absolute fracture risk model (FRAX).

The risk for a second fragility fracture decreases as time passes from the first fracture. The study by Johnell et al. found that for all fractures, more fractures occurred in the first year after fracture than in subsequent years. The number of fractures decreased progressively thereafter with time. Schousboe et al. found that prior non-spine, non-hip fracture confers a modest excess risk for incident hip fracture independent of BMD after 10 years; that excess risk, however, was only about one-third the excess risk during the first 5 years of follow-up.

The AACE recommends alendronate, risedronate, zoledronic acid, or denosumab as first-line agents. For patients unable to use oral therapy, teriparatide, denosumab, or zoledronic acid should be considered as initial therapy. Teriparatide, denosumab, or zoledronic acid can be considered as initial therapy for those who have the highest fracture risk (e.g., older women who have had multiple vertebral fractures or hip fractures, or who have very low T-scores). For patients at high risk of spine fracture but not at risk for hip or nonvertebral fractures, ibandronate and raloxifene may be appropriate, and raloxifene has a “side benefit” of reducing breast cancer risk. Raloxifene or ibandronate may be appropriate initial therapy in some cases where patients require drugs with spine-specific efficacy. Denosumab is the agent of choice for patients with renal insufficiency, but this agent is not recommended for dialysis patients or those with stage 5 kidney disease due to the high risk of hypocalcemia.

Due to the lack of evidence on the effect on fracture risk, concomitant use of osteoporosis agents is not recommended.

### **Clinical Studies**

Evenity Study 1 was a randomized double-blind, placebo-controlled study of postmenopausal women age 55 to 90 years with BMD T-scores  $\leq 2.5$  at the total hip or femoral neck. Women were randomized to receive either Evenity or placebo for 12 months. After the 12-month treatment period, women in both arms transitioned to denosumab for 12 months. Evenity was shown to significantly reduce the incidence of new vertebral fractures through 12 months compared to placebo. In addition, the significant reduction in fracture risk persisted through the second year in women who received Evenity and were transitioned to denosumab. Evenity also significantly increased BMD at the lumbar spine, total hip, and femoral neck compared with placebo at month 12. Following the transition to denosumab at month 12, BMD continued to increase through month 24. BMD also increased with patients transitioned from placebo to denosumab. The differences in BMD achieved at month 12 between Evenity and placebo patients were overall maintained at month 24 when comparing patients who transitioned from Evenity to those that transitioned from placebo.

Evenity Study 2 was a randomized, double-blind, alendronate-controlled study of postmenopausal women aged 55 to 90 years with BMD T-scores less than or equal to -2.5 at the total hip or femoral neck and either two moderate or severe vertebral fractures or a history of a proximal femur fracture. Women were randomized to either receive monthly injections of Evenity or oral alendronate 70 mg weekly for 12 months. After the 12-month period, both arms were transitioned to alendronate 70 mg weekly. Evenity significantly reduced the risk of clinical fracture through the end of the primary analysis period with a 50% risk reduction compared to a 4% reduction in the alendronate arm. Evenity followed by alendronate also significantly reduced the risk of nonvertebral fracture through the primary analysis period, with a hazard ratio of 0.81 compared to alendronate alone.

The anabolic effect of Evenity wanes after 12 monthly doses of therapy. Therefore, the duration of Evenity use should be limited to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered.

### **Safety**

Evenity carries several black box warnings. Evenity may increase the risk of myocardial infarction, stroke and cardiovascular death. Evenity should not be initiated in patients who have had a myocardial infarction or stroke within the preceding year. Consider whether the benefits outweigh the risks in patients with other

cardiovascular risk factors. If a patient experiences a myocardial infarction or stroke during therapy, Evenity should be discontinued.

Evenity carries the following contraindications:

- Hypocalcemia
- Known hypersensitivity to Evenity or to any component of the product formulation

Pre-existing hypocalcemia must be corrected prior to initiating therapy with Evenity.

## CODING

### BlueCHiP for Medicare

The following HCPCS code is covered when the medical criteria have been met:

**J3111** Injection, romosozumab-aqqg, 1 mg

## RELATED POLICIES

Prior Authorization of Drugs

## PUBLISHED

Provider Update, October 2019

## REFERENCES

1. Evenity prescribing information. Amgen Pharmaceuticals. April 2019.
2. Camacho PM, Petak SM, Binkley N, et al. American Association of Clinical Endocrinologists and American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis – 2016. Available at <https://www.aace.com/files/postmenopausal-guidelines.pdf>. Accessed 5/6/2019.
3. North American Menopause Society. Management of osteoporosis in postmenopausal women: 2010 position statement of the North American Menopause Society. *Menopause*. 2010;17(1):25-54.
4. Kanis JA. Assessment of fracture risk and its application to screening for postmenopausal osteoporosis synopsis of a WHO report. WHO study Group. *Osteoporosis Int*. 1994;4:368-381.
5. National Osteoporosis Foundation (NOF) Clinician's Guide to Prevention and Treatment of Osteoporosis. 2014. Accessed 8/26/2014 <https://cdn.nof.org/wp-content/uploads/2016/01/995.pdf>
6. World Health Organization (WHO) Scientific Group on the Assessment of Osteoporosis at Primary Health Care Level. May 2004. Available at: <http://www.who.int/chp/topics/Osteoporosis.pdf>. Accessed 5/6/2019.
7. Johnell O, Kanis JA, Oden, et al. Fracture risk following an osteoporotic fracture. *Osteoporosis Int*. 2004;15:175-179.
8. Schousboe JT, Fink HA, Lui LY, et al. Association between prior non-spine non-hip fractures or prevalent radiographic vertebral deformities known to be at least 10 years old and incident hip fracture. *J Bone Miner Res*. 2006;21:1557-1564.

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