Program: Bisphosphonates

DESCRIPTION

The purpose of this document is to provide approval criteria and guidelines for prior authorization of benefits (PAB) of bisphosphonates.
Claims submitted without obtaining prior authorization of benefits will reject on the pharmacy claim system.

Applicable lines of business
RIteCare and Managed Pharmacy

Impacted Formulary Medications

Preferred Generic
alendronate tablets 5mg, 10mg, 35mg, 40mg, 70mg

Non-Preferred Brand
Actonel tablets (risedronate) 5mg, 30mg, 35mg, 75mg, 150mg
Actonel with Calcium (risedronate) 35mg tablets
Boniva (ibandronate) 2.5mg, 150mg tablets
Fosamax (alendronate) tablets 5mg, 10mg, 35mg, 40mg, 70mg, 70mg oral solution
Fosamax Plus D (alendronate) 70mg alendronate/70mcg vitamin D_3, 70mg alendronate/140mcg vitamin D_3

APPROVAL DURATION AND QUANTITY LIMITS
Approval Duration: Lifetime

APPROVAL CRITERIA:
I. Requests for a *Non-Preferred* brand name bisphosphonate may be approved if the patient meets the following criteria:
A. Patient has had at least a 5 day trial of a preferred generic bisphosphonate in the previous 180 days

Look Back Criteria in Claims System
Look back 180 days for at least a 5 days supply of a generic bisphosphonate, if yes, approve, if no, reject for PA.