



STEP THERAPY POLICY

- POLICY:** Bisphosphonates (Oral) Enhanced Step Therapy Policy
- Actonel® (risedronate tablets – AbbVie [5, 30, 35, and 150 mg, generic])
 - Atelvia® (risedronate delayed-release tablets – AbbVie, generic)
 - Binosto® (alendronate effervescent tablets for oral solution – Radius)
 - Boniva® (ibandronate tablets – Genentech/Roche, generic)
 - Fosamax® (alendronate tablets – Organon, generic)
 - Fosamax® Plus D (alendronate/cholecalciferol tablets – Organon)

REVIEW DATE: 10/15/2025

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT WHERE APPROPRIATE AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. WHERE COVERAGE FOR CARE OR SERVICES DOES NOT DEPEND ON SPECIFIC CIRCUMSTANCES, REIMBURSEMENT WILL ONLY BE PROVIDED IF A REQUESTED SERVICE(S) IS SUBMITTED IN ACCORDANCE WITH THE RELEVANT CRITERIA OUTLINED IN THE APPLICABLE COVERAGE POLICY, INCLUDING COVERED DIAGNOSIS AND/OR PROCEDURE CODE(S). REIMBURSEMENT IS NOT ALLOWED FOR SERVICES WHEN BILLED FOR CONDITIONS OR DIAGNOSES THAT ARE NOT COVERED UNDER THIS COVERAGE POLICY (SEE "CODING INFORMATION" BELOW). WHEN BILLING, PROVIDERS MUST USE THE MOST APPROPRIATE CODES AS OF THE EFFECTIVE DATE OF THE SUBMISSION. CLAIMS SUBMITTED FOR SERVICES THAT ARE NOT ACCOMPANIED BY COVERED CODE(S) UNDER THE APPLICABLE COVERAGE POLICY WILL BE DENIED AS NOT COVERED. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Alendronate tablets are indicated for the following uses:¹

- Treatment and prevention of **postmenopausal osteoporosis**.
- Treatment of **glucocorticoid-induced osteoporosis** in men and women.
- Treatment of **Paget's disease** in men and women.
- Increase **bone mass** in men with osteoporosis.

Binosto and **Fosamax Plus D** tablets are indicated for the following uses:^{5,6}

- Treatment of **postmenopausal osteoporosis**.
- Treatment to increase **bone mass** in men with osteoporosis.

Ibandronate tablets are indicated for the treatment and prevention of **postmenopausal osteoporosis**.⁴

Risedronate tablets are indicated for the following uses:²

- Treatment and prevention of **postmenopausal osteoporosis**.
- Treatment and prevention of **glucocorticoid-induced osteoporosis** in men and women.
- Treatment of **Paget's disease** in men and women.
- Increase **bone mass** in men with osteoporosis.

Risedronate delayed-release tablets are indicated for the treatment of **postmenopausal osteoporosis**.³

Alendronate, risedronate, risedronate delayed-release tablets, and ibandronate tablets are orally administered bisphosphonates.¹⁻⁴ Fosamax Plus D contains alendronate plus vitamin D₃ in one tablet; both are available as single-entity products.⁵ Binosto provides alendronate in a 70 mg effervescent tablet for oral solution.⁶ The prescribing information for Fosamax notes that although an oral solution of alendronate may be available in the marketplace, Fosamax oral solution is no longer marketed.¹ Boniva was discontinued in 2023; generic ibandronate is available.

POLICY STATEMENT

This program has been developed to encourage the use of a Step 1 Product prior to the use of a Step 2 Product, and the use of a Step 2 Product prior to the use of a Step 3 Product. If the Step Therapy rule is not met for the Step 2 Product or the Step 3 Product at the point of service, coverage will be determined by the Step Therapy criteria below. All approvals are provided for 1 year in duration.

Note: Generic alendronate oral solution (70 mg/75 mL) is not included in this policy.

Step 1: alendronate 5, 10, 35, 40 and 70 mg tablets, ibandronate 150 mg tablets, risedronate 5, 30, 35, and 150 mg tablets, risedronate 35 mg delayed-release tablets

Step 2: Atelvia delayed-release tablets

Step 3: Actonel tablets, Binosto effervescent tablets, Boniva tablets, Fosamax tablets, Fosamax Plus D tablets

***Bisphosphonates (Oral) Enhanced Step Therapy Policy* product(s) is(are) covered as medically necessary when the following step therapy criteria is(are) met. Any other exception is considered not medically necessary.**

CRITERIA

1. If the patient has tried one Step 1 Product, approve a Step 2 Product.
2. If the patient has tried one Step 1 Product and one Step 2 Product, approve a Step 3 Product.
3. Approve Binosto if the patient meets one the following (A or B):
A) Patient has a gastrostomy tube (G-tube); OR
B) Patient cannot swallow or has difficulty swallowing tablets or capsules.

REFERENCES

1. Fosamax® tablets and oral solution [prescribing information]. Jersey City, NJ: Organon; June 2021.
2. Actonel® tablets [prescribing information]. North Chicago, IL: AbbVie; October 2023.
3. Atelvia® delayed-release tablets [prescribing information]. North Chicago, IL: AbbVie; October 2023.
4. Ibandronate tablets [prescribing information]. Weston, FL: Apotex; August 2023.
5. Fosamax® Plus D tablets [prescribing information]. Jersey City, NJ: Organon; August 2021.
6. Binosto® effervescent tablets for oral solution [prescribing information]. Boston, MA: Radius; October 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	11/08/2023
Annual Revision	No criteria changes.	10/02/2024
Annual Revision	No criteria changes.	10/15/2025

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