

Clinical Policy: Zoledronic Acid (Reclast, Zometa)

Reference Number: CP.PHAR.59

Effective Date: 03.11

Last Review Date: 02.21

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

Zoledronic acid (Reclast[®], Zometa[®]) is a bisphosphonate.

FDA Approved Indication(s)

Reclast is indicated:

- Postmenopausal osteoporosis (PMO) - treatment: For the treatment of osteoporosis in postmenopausal women. In postmenopausal women with osteoporosis, diagnosed by bone mineral density (BMD) or prevalent vertebral fracture, Reclast reduces the incidence of fractures (hip, vertebral, and non-vertebral osteoporosis-related fractures). In patients at high risk of fracture, defined as a recent low-trauma hip fracture, Reclast reduces the incidence of new clinical fractures;
- PMO - prevention: For the prevention of osteoporosis in postmenopausal women;
- Male osteoporosis - treatment: For the treatment to increase bone mass in men with osteoporosis;
- Glucocorticoid-induced osteoporosis - prevention and treatment: For the treatment and prevention of GIO in men and women who are either initiating or continuing systemic glucocorticoids in a daily dosage equivalent to 7.5 mg or greater of prednisone and who are expected to remain on glucocorticoids for at least 12 months;
- Paget disease: For the treatment of Paget's disease of bone in men and women with elevations in serum alkaline phosphatase (ALP) of two times or higher than the upper limit of the age-specific normal reference range, or those who are symptomatic, or those at risk for complications from their disease.

Limitation(s) of use: The safety and effectiveness of Reclast for the treatment of osteoporosis is based on clinical data of three years duration. The optimal duration of use has not been determined. All patients on bisphosphonate therapy should have the need for continued therapy re-evaluated on a periodic basis. Patients at low-risk for fracture should be considered for drug discontinuation after 3 to 5 years of use. Patients who discontinue therapy should have their risk for fracture re-evaluated periodically.

Zometa is indicated:

- Hypercalcemia of malignancy: For the treatment of hypercalcemia of malignancy defined as an albumin-corrected calcium (cCa) of greater than or equal to 12 mg/dL (3.0 mmol/L);
- Multiple myeloma (MM): For the treatment of patients with multiple myeloma;
- Solid tumors: For the treatment of patients with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy. Prostate cancer should have progressed after treatment with at least one hormonal therapy.

Limitation(s) of use: The safety and efficacy of Zometa in the treatment of hypercalcemia associated with hyperparathyroidism or with other non-tumor-related conditions have not been established.

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.

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It is the policy of health plans affiliated with Centene Corporation[®] that Reclast and Zometa are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Osteoporosis (must meet all):

1. Request is for Reclast;
2. Prescribed for one of the following uses (a or b):
 - a. Treatment or prevention of PMO or GIO;
 - b. Treatment of male osteoporosis;
3. Age \geq 18 years or documentation of closed epiphyses on x-ray;
4. Failure of a 12-month trial of oral bisphosphonate therapy (*see Appendix B; alendronate is preferred*) at up to maximally indicated doses, unless all are contraindicated or clinically significant adverse effects are experienced;
**Prior authorization may be required for oral bisphosphonates*
5. Reclast is not prescribed concurrently with Zometa;
6. Dose does not exceed 5 mg.

Approval duration:

Medicaid/HIM – osteoporosis treatment: 12 months (one infusion); osteoporosis prevention: 24 months (one infusion)

Commercial – 6 months or to the member’s renewal date, whichever is longer

B. Paget Disease (must meet all):

1. Request is for Reclast
2. Diagnosis of Paget disease of the bone;
3. Age \geq 18 years or documentation of closed epiphyses on x-ray;
4. Failure of a 12-month trial of oral bisphosphonate therapy (*see Appendix B; alendronate is preferred*) at up to maximally indicated doses, unless all are contraindicated or clinically significant adverse effects are experienced (*Appendix E*);
**Prior authorization may be required for oral bisphosphonates*
5. Reclast is not prescribed concurrently with Zometa;
6. Dose does not exceed 5 mg.

Approval duration:

Medicaid/HIM – 12 months (one infusion)

Commercial – 6 months or to the member’s renewal date, whichever is longer

C. Hypercalcemia of Malignancy (must meet all):

1. Request is for Zometa;
2. Diagnosis of hypercalcemia of malignancy;
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years or documentation of closed epiphyses on x-ray;
5. Albumin-corrected calcium \geq 12 mg/dL;
7. Zometa is not prescribed concurrently with Reclast;
8. Dose does not exceed 4 mg.

Approval duration:

Medicaid/HIM – 1 week (one infusion)

Commercial – 6 months or to the member’s renewal date, whichever is longer

D. Multiple Myeloma or Solid Tumor (must meet all):

1. Request is for Zometa;
2. Diagnosis of one of the following (a or b):
 - a. MM, and member is receiving or initiating therapy (e.g., chemotherapy, transplant) for symptomatic disease;
 - b. Bony metastasis from solid tumor (e.g., breast, kidney, lung, prostate, thyroid);
3. Prescribed by or in consultation with an oncologist;
4. Age \geq 18 years or documentation of closed epiphyses on x-ray;
5. Zometa is not prescribed concurrently with Reclast;
6. Dose does not exceed 4 mg.

Approval duration:

Medicaid/HIM – 3 months (one infusion every 3 weeks)

Commercial – 6 months or to the member’s renewal date, whichever is longer

E. Prostate/Breast Cancer - Fracture Prevention (off-label) (must meet all):

1. Request is for Zometa;

2. Diagnosis of one of the following (a or b):
 - a. Prostate cancer and member is receiving androgen deprivation therapy (e.g., leuprolide (Lupron[®]), bicalutamide (Casodex[®]), Nilandron[®]);
 - b. Breast cancer and member is receiving adjuvant endocrine therapy (e.g., tamoxifen or aromatase inhibitors such as anastrozole (Arimidex[®]), exemestane (Aromasin[®]) or letrozole (Femara[®]));
 3. Prescribed by or in consultation with an oncologist;
 4. Age \geq 18 years or documentation of closed epiphyses on x-ray;
 5. Zometa is not prescribed concurrently with Reclast;
 6. Request meets one of the following (a or b):*
 - a. Dose does not exceed 4 mg;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
- *Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:

Medicaid/HIM – 3 months (one infusion every 3 weeks)

Commercial – 6 months or to the member’s renewal date, whichever is longer

F. Systemic Mastocytosis (off-label) (must meet all):

1. Request is for Zometa;
 2. Diagnosis of systemic mastocytosis;
 3. Member has osteopenia or osteoporosis with bone pain;
 4. Prescribed by or in consultation with an oncologist;
 5. Age \geq 18 years or documentation of closed epiphyses on x-ray;
 6. Zometa is not prescribed concurrently with Reclast;
 7. Request meets one of the following (a or b):*
 - a. Dose does not exceed 4 mg;
 - b. Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*
- *Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:

Medicaid/HIM – 3 months (one infusion every 3 weeks)

Commercial – 6 months or to the member’s renewal date, whichever is longer

G. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Osteoporosis and Paget Disease of Bone (must meet all):

1. Request is for Reclast;
2. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
3. Member is responding positively to therapy;

4. If request is for a dose increase, new dose does not exceed 5 mg.

Approval duration:

Medicaid/HIM – osteoporosis treatment and Paget disease: 12 months (one infusion);
osteoporosis prevention: 24 months (one infusion)

Commercial – 6 months or to the member’s renewal date, whichever is longer

B. Oncology-Related Indications (must meet all):

1. Request is for Zometa;
2. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zometa for a covered indication and has received this medication for at least 30 days;
3. Member is responding positively to therapy;
4. If request is for a dose increase, request meets one of the following (a or b):*
 - a. New dose does not exceed 4 mg;
 - b. New dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).

**Prescribed regimen must be FDA-approved or recommended by NCCN.*

Approval duration:

Medicaid/HIM – hypercalcemia of malignancy: 1 week (one infusion); all other indications: 12 months (one infusion every 3 weeks)

Commercial – 6 months or to the member’s renewal date, whichever is longer

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 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.PHAR.21 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

MM: multiple myeloma

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Oral bisphosphonates		
alendronate (Fosamax [®])	Treatment/prevention: PMO Treatment: GIO, male osteoporosis Treatment: Paget disease <i>See prescribing information for dose.</i>	Varies
Fosamax [®] Plus D (alendronate / cholecalciferol)	Treatment: PMO, male osteoporosis <i>See prescribing information for dose.</i>	
risedronate (Actonel [®] , Atelvia [®])	Actonel: Treatment/prevention: PMO, GIO Treatment: male osteoporosis Treatment: Paget disease Atelvia: Treatment: PMO <i>See prescribing information for dose.</i>	
ibandronate (Boniva [®])	Treatment/prevention: PMO <i>See prescribing information for dose.</i>	

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):
 - Hypersensitivity to any product component
 - Reclast: hypocalcemia, creatinine clearance < 35 mL/min, acute renal impairment
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Zoledronic acid (Reclast)	Treatment: PMO, male osteoporosis Treatment/prevention: GIO	5 mg IV once a year	5 mg/year
	Prevention: PMO	5 mg IV once every 2 years	5 mg/2 years
	Paget disease	5 mg IV once; retreatment may be considered	5 mg
Zoledronic acid (Zometa)	Hypercalcemia of malignancy	4 mg as a single-use IV infusion; may re-treat with 4 mg after a minimum of 7 days	4 mg/infusion
	MM	4 mg as a single-use IV infusion every 3 to 4 weeks	4 mg/3 weeks

Drug Name	Indication	Dosing Regimen	Maximum Dose
	Solid tumor - bone metastasis		

VI. Product Availability

Drug Name	Availability
Zoledronic acid (Reclast)	Ready-to-infuse solution: 5 mg/100 mL
Zoledronic acid (Zometa)	Ready-to-infuse solution: 4 mg/100 mL Single-use vial concentrate: 4 mg/5 mL

VII. References

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Paget Disease

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Oncology

13. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at www.nccn.org. Accessed November 03, 2020.

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16. National Comprehensive Cancer Network. Prostate Cancer Version 2.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/prostate.pdf. Accessed October 26, 2020.

17. National Comprehensive Cancer Network. Systemic Mastocytosis Version 1.2020. Available at: https://www.nccn.org/professionals/physician_gls/pdf/mastocytosis.pdf. Accessed October 26, 2020.

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
J3489	Injection, zoledronic acid, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Removed age restriction. Added maximum dose to continued therapy. Certain conditions representing potential contraindications to therapy and other safety criteria removed. Osteoporosis and Paget’s disease: Removed high risk of fracture (recent low-trauma hip fracture). Added “at total hip” to T score. Added requirement for T score/history of fracture to confirm diagnosis of male osteoporosis, and combined treatment of osteoporosis of postmenopausal women and males. Removed requirement for administration of calcium/vitamin D if appropriate. For Paget’s disease, removed requirement for trial/failure of an oral bisphosphonate. Hypercalcemia, multiple myeloma, and bone metastases: Removed requirement that multiple myeloma must be active, and	02.17	03.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
deleted appendix C (definition of active MM). Removed CrCl < 30 (a warning) and hypercalcemia associated with hyperparathyroidism (a limitation of use) from contraindications. Added requirement for member to continue to be receiving oral calcium and vitamin D to continued therapy. Added reasons to discontinue to continued therapy		
1Q18 annual review: policies combined commercial and Medicaid; converted to new template; modified diagnoses and removed requirements for evidence of diagnoses for Reclast indications; modified age requirement. Modified criteria to add specialist requirement or trial and failure of a bisphosphonate (alendronate is preferred). Removed definition of treatment failure; removed contraindication of hypocalcemia; modified approval duration of 24 months to apply only to postmenopausal osteoporosis prevention; modified approval duration for other diagnoses/indications to 12 months; removed requirements for calcium and vitamin D supplementation; modified definitions for positive response to therapy; added requirement for continuation of standard antineoplastic therapy for multiple myeloma and bone metastases; references reviewed and updated.	11.22.17	02.18
1Q 2019 annual review: added HIM line of business; modified Paget’s disease to only require diagnosis; added geriatrician prescriber option; removed previous requirement that psychiatrist prescriber applies only to postmenopausal osteoporosis; modify approval duration for Commercial to “6 months or to the member’s renewal date, whichever is longer”; references reviewed and updated.	11.01.18	02.19
1Q 2020 annual review: removed HIM disclaimer for HIM NF drugs; Reclast: closed epiphyses added if less than 18 years; Paget disease - continuation criteria removed for individualization of therapy; Zometa: oncology - examples of skeletal related event and solid tumor added; oncologist and age added; NCCN recommended breast/prostate cancer and systemic mastocytosis uses added; hypercalcemia continuation of therapy criteria removed given response fluidity; references reviewed and updated.	11.19.19	02.20
1Q 2021 annual review: The MM/solid tumor common criteria line item, at risk for skeletal related event, is removed for solid tumor and for MM is replaced with receiving or initiating therapy for symptomatic disease per pivotal trials/NCCN; references reviewed and update.	11.03.20	02.21

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.

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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.

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