

## **Clinical Policy: Ospemifene (Osphena)**

Reference Number: CP.PMN.168

Effective Date: 08.28.18

Last Review Date: 11.20

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Ospemifene (Osphena<sup>®</sup>) is a selective estrogen receptor modulator (SERM).

### **FDA Approved Indication(s)**

Osphena is indicated for the treatment of moderate to severe dyspareunia and vaginal dryness, symptoms of vulvar and vaginal atrophy, due to menopause.

### **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.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Osphena is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Dyspareunia or Vaginal Dryness (must meet all):**

1. Diagnosis of dyspareunia or vaginal dryness due to menopause;
2. Age  $\geq$  18 years;
3. Failure of two vaginal lubricants or vaginal moisturizers at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Failure of  $\geq$  4 weeks of one vaginal estrogen at up to maximally indicated doses (e.g., estradiol vaginal cream, Premarin<sup>®</sup> vaginal cream), unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 60 mg (1 tablet) per day.

#### **Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – Length of Benefit

### **B. 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. Dyspareunia or Vaginal Dryness (must meet all):**

1. Currently receiving medication via Centene benefit, or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 60 mg (1 tablet) per day.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – Length of Benefit

**B. 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 12 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*

FDA: Food and Drug Administration

SERM: selective estrogen receptor modulator

*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 for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
estradiol vaginal cream (Estrace <sup>®</sup> )	Initial: 2 to 4 gm vaginally QD for 1 to 2 weeks, gradually reduce to 50% of initial dose for 1 to 2 weeks Maintenance: 1 gm 1 to 3 times a week	Varies
Premarin <sup>®</sup> (conjugated estrogens) vaginal cream	0.5 gm intravaginally twice per week continuously	Varies
estradiol vaginal tablet (Vagifem <sup>®</sup> )	1 tablet intravaginally QD for 2 weeks, followed by 1 tablet twice weekly	1 tablet/day
Estring <sup>®</sup> (estradiol vaginal ring)	2 mg intravaginally for 90 days	2 mg every 90 days
Vaginal lubricants: <i>Water-based</i>	Apply intravaginally before sex	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Astroglide <sup>®</sup> , FemGlide <sup>®</sup> , Just Like Me <sup>®</sup> , K-Y Jelly <sup>®</sup> , Pre-Seed <sup>®</sup> , Slippery Stuff <sup>®</sup> , Summer's Eve <sup>®</sup> <i>Silicone-based</i> ID Millennium <sup>®</sup> , Pink <sup>®</sup> , Pjur <sup>®</sup> , Pure Pleasure <sup>®</sup>		
Vaginal moisturizers: Fresh Start <sup>®</sup> , K-Y Silk-E <sup>®</sup> , Moist Again <sup>®</sup> , Replens <sup>®</sup> , K-Y Liquibeads <sup>®</sup>	Apply intravaginally before sex	Varies

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): undiagnosed abnormal genital bleeding; estrogen-dependent neoplasia; history of or active deep vein thrombosis, pulmonary embolism, thromboembolic disease (for example, stroke and myocardial infarction); hypersensitivity; known or suspected pregnancy
- Box warning(s): endometrial cancer, stroke and deep vein thrombosis.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Moderate to severe dyspareunia or vaginal dryness due to menopause	60 mg PO QD	60 mg/day

**VI. Product Availability**

Tablet: 60 mg

**VII. References**

1. Ospheña Prescribing Information. Florham Park, NJ: Shionogi Inc.; January 2019. Available at: <http://www.osphena.com/>. Accessed August 13, 2020.
2. American College of Obstetricians and Gynecologists Committee on Practice Bulletins-Gynecology. ACOG Practice Bulletin No. 213: Female sexual dysfunction. *Obstet Gynecol.* 2019 Jul;134(1):203-205
3. Pinkerton JV, Aguirre FS, Blake J, et al. The 2017 hormone therapy position statement of The North American Menopause Society. *Menopause.* 2017;24(7):728-753. doi:10.1097/GME.0000000000000921.
4. Faubion S, Sood R, Kapoor E. Genitourinary Syndrome of Menopause: Management Strategies for the Clinician. *Mayo Clin Proc.* 2017 Dec;92(12):1842-1849. doi: 10.1016/j.mayocp.2017.08.019.
5. Stuenkel C, Davis S, Gompel A, et al. Treatment of Symptoms of the Menopause: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, Volume 100, Issue 11, 1 November 2015, Pages 3975–4011,

<https://doi.org/10.1210/jc.2015-2236>

6. Vaginal and Vulvar Comfort: Effective Treatments for Sexual Problems. The North American Menopause Society. Available at: <https://www.menopause.org/for-women/sexual-health-menopause-online/effective-treatments-for-sexual-problems>. Accessed August 8, 2019.
7. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 13, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.28.18	11.18
Criteria added for new FDA indication: treatment of moderate to severe vaginal dryness; references reviewed and updated.	03.05.19	05.19
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.08.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.13.20	11.20

**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.

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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.

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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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