Clinical Policy: Denosumab (Xgeva), Denosumab-bbdz (Wyost)

Reference Number: LA.PHAR.58
Effective Date: 04.21
Last Review Date: 10.04.24
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Denosumab (Xgeva®) and its biosimilar, denosumab-bbdz (Wyost®) are receptor activators of nuclear factor kappa-B ligand inhibitor.

FDA Approved Indication(s)

Xgeva and Wyost are indicated:

- For the prevention of skeletal-related events in patients with multiple myeloma (MM) and in patients with bone metastases from solid tumors.
- For the treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity.
- For the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.

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 Louisiana Healthcare Connections that Xgeva and Wyost are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Request is for Xgeva or Wyost;
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. Bone metastasis secondary to solid tumor (e.g., breast, kidney, lung, prostate, thyroid);
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years or documentation of closed epiphyses on x-ray;
5. For indications other than prostate or breast cancer, member meets the following:
   a. Failure of zoledronic acid* (Zometa) or pamidronate* at up to maximally indicated doses, unless clinically significant adverse effects are experienced or both are contraindicated (*see Appendices B and D*);
   **Prior authorization may be required.*
6. Xgeva or Wyost are not prescribed concurrently with Prolia or Jubbonti;
7. Dose does not exceed 120 mg every 4 weeks.

Approval duration: 6 months

B. Giant Cell Tumor of Bone (must meet all)**:**

1. Request is for Xgeva or Wyost;
2. Diagnosis of giant cell tumor of bone that is characterized as one of the following (a or b):
   a. Metastatic or unresectable disease;
   b. Localized disease, and Xgeva is prescribed as a single agent or in combination with interferon alfa or radiation therapy;

3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years or documentation of closed epiphyses on x-ray;
5. Xgeva or Wyost are not prescribed concurrently with Prolia or Jubbonti;
6. Dose does not exceed 120 mg every 4 weeks plus 120 mg on days 8 and 15 of first month of therapy.

Approval duration: 6 months

C. Hypercalcemia of Malignancy (must meet all)**:**

1. Request is for Xgeva or Wyost;
2. Diagnosis of hypercalcemia of malignancy;
3. Prescribed by or in consultation with an oncologist;
4. Age ≥ 18 years or documentation of closed epiphyses on x-ray;
5. Albumin-corrected calcium > 12.5 mg/dL despite IV bisphosphonate therapy in the last 30 days (*see Appendix B*);
   **Prior authorization may be required.*
6. Xgeva or Wyost are not prescribed concurrently with Prolia or Jubbonti;
7. Dose does not exceed 120 mg every 4 weeks plus 120 mg on days 8 and 15 of first month of therapy.

Approval duration: 6 months

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

1. Request is for Xgeva or Wyost;
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 ≥ 18 years or documentation of closed epiphyses on x-ray;
6. Member meets the following:
   a. Failure of zoledronic acid* (Zometa) or pamidronate* at up to maximally indicated doses unless clinically significant adverse effects are experienced or both are contraindicated *(see Appendices B and D)*;
      **Prior authorization may be required.*
7. Xgeva or Wyost are not prescribed concurrently with Prolia or Jubbonti;
8. Dose is within FDA maximum limit for any FDA-approved indication or 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: 6 months

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

a. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving Xgeva or Wyost for a covered cancer-related indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed
   a. Xgeva or Wyost: 120 mg every 4 weeks or 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: 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g. diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

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 policy – LA.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADT: androgen deprivation therapy
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
IV bisphosphonates		
ibandronate (Boniva®)	Treatment: PMO Hypercalcemia of malignancy (*off-label)*	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
zoledronic acid (Reclast®; Zometa®)	Reclast: Treatment/prevention: PMO, GIO Treatment: male osteoporosis Zometa: MM Bone metastasis from solid tumors Hypercalcemia of malignancy Systemic mastocytosis *(off-label)* Fracture prevention - breast/prostate cancer (*off-label*)	*See prescribing information and compendia for dosing.*
pamidronate	MM Bone metastasis from breast cancer Hypercalcemia of malignancy Systemic mastocytosis *(off-label)* Fracture prevention – breast/prostate cancer (*off-label*)	
Oral bisphosphonates		
alendronate (Fosamax®)	Treatment: PMO Treatment: GIO, male osteoporosis	Varies *See prescribing information and compendia for dosing.*
Fosamax® Plus D (alendronate / cholecalciferol)	Treatment: PMO, male osteoporosis	
risedronate (Actonel®, Atelvia®)	Actonel: Treatment: PMO, GIO Treatment: male osteoporosis Atelvia: Treatment: PMO	
ibandronate (Boniva®)	Treatment/prevention: PMO	

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):
  - Xgeva and Wyost: hypocalcemia, known clinically significant hypersensitivity to Xgeva or Wyost
- Boxed warning(s): none reported

Appendix D: IV/PO Bisphosphonates: Examples of Contraindications and Adverse Effects

Bisphosphonates	Oral Formulations	IV Formulations
Contraindications		
Hypocalcemia	X	X
Increased risk of aspiration	X	-
Hypersensitivity to product component	X	X

Bisphosphonates	Oral Formulations	IV Formulations
Inability to stand/sit upright for at least 30 minutes	X	-
Creatinine clearance < 35 mL/min or evidence of acute renal impairment	-	X
Esophagus abnormalities which delay emptying such as stricture or achalasia	X	-
Clinically significant warnings or adverse side effects		
Pregnancy	X	X
Eye inflammation	X	X
Acute renal failure	X	X
Osteonecrosis of the jaw	X	X
Atypical femoral shaft fracture	X	X
Drug interactions (product-specific)	X	X
Severe or incapacitating musculoskeletal pain	X	X

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Denosumab (Xgeva, Wyost)	MM Solid tumor - bone metastasis	120 mg SC once every 4 weeks	20 mg/dose
	Giant cell tumor of bone Hypercalcemia of malignancy	120 mg SC every 4 weeks plus 120 mg on Days 8 and 15 of first month of therapy	120 mg/dose

VI. Product Availability

Drug Name	Availability
Denosumab (Xgeva, Wyost)	Injection (single-use vial): 120 mg/1.7 mL (70 mg/mL)

VII. References

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2. Jubbonti Prescribing Information. Princeton, NJ: Sandoz Inc.: March 2024. Available at: http://www.jubbonti.com. Accessed March 13, 2024.
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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
J0897	Injection, denosumab, 1 mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted corporate to local policy.	01.21	04.21
Removed Prolia criteria. LDH Prolia criteria utilized for Physician Administered Medication Prior Authorizations. For multiple myeloma or solid tumor and systemic mastocytosis: allowed bypassing of redirection of step therapy in Stage IV or metastatic cancer settings.	04.22	07.01.22
Template changes applied to other diagnoses/indications and continued therapy section. References reviewed and updated. Added blurb this policy is for medical benefit only. Minor grammatical and formatting edits. Updated maximum dosage for MM.	06.27.23	01.03.24
Annual review; no material changes to policy content; appendices updated for clarity, references reviewed and updated.	05.07.24	08.20.24
Added new biosimilar Wyost to policy; Added HCPCS code [Q5136]. Removal of Appendix E, as LDH Pharmacy has previously clarified that the cancer provisions referenced do not apply to the Medicaid line of business. References reviewed and updated.	10.04.24	

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. LHCC 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.

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 LHCC administrative policies and procedures.

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