GENERIC STEP THERAPY PLANS (GSTP)

DRUG CLASS **BISPHOSPHONATES**

PGST SSB: Binosto, Fosamax Plus D

HPGST SSB: Binosto, Fosamax Plus D

TGST SSB: Binosto, Fosamax Plus D

Status: CVS Caremark Criteria
Type: Initial Step Therapy; Post Step Therapy Prior Authorization

POLICY

INITIAL STEP THERAPY

If the patient has filled a prescription for at least a 28 day supply of at least one generic bisphosphonate within the past 365 days under a prescription benefit administered by CVS Caremark, then the requested branded drug will be paid under that prescription benefit. If the patient does not meet the initial step therapy criteria, then the claim will reject with a message indicating that a prior authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

COVERAGE CRITERIA

The requested branded bisphosphonate will be covered with post step therapy prior authorization when the following criteria are met:

- The patient has experienced an inadequate treatment response (as determined on most recent DEXA scan) after a sufficient trial of a generic bisphosphonate drug
  OR
- The patient has a documented contraindication or potential drug interaction that would prohibit a trial with at least one generic bisphosphonate drug
  OR
- The patient has experienced an intolerance to at least one generic bisphosphonate drug

REFERENCES

N/A