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Policy Number: C8849-A

Xgeva (denosumab) and Biosimilars

PRODUCTS AFFECTED

Aukelso (denosumab-kyqq), Bilprevda (denosumab-nxxp), Bomyntra (denosumab-bnht), denosumab-bnht, denosumab-dssb, Jubereq (denosumab-desu), Osenvelt (denosumab-bmwo), Oziltus (denosumab-mobz), Wyost (denosumab-bbdz), Xbryk (denosumab-dssb), Xgeva (denosumab), Xtrenbo (denosumab-qbde)
*Prolia (denosumab) – SEE PROLIA (DENOSUMAB) AND BIOSIMILARS MHI C8848-A

COVERAGE POLICY

Coverage for services, procedures, medical devices, and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Bone metastases from solid tumors, Giant cell tumor of bone, Hypercalcemia of malignancy, Multiple myeloma

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific

measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. ALL INDICATIONS:
   1. (a) IF THIS IS A PHARMACY BENEFIT REQUEST FOR A NON-FORMULARY/NON-PREFERRED PRODUCT: Documentation of trial/failure of or serious side effects to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis. Documentation of medication(s) tried, dates of trial(s) and reason for treatment failure(s) is required.
      AND
      (b) If request is for reference product with a biosimilar available for initial or continuation of therapy requests: Documentation of a trial and failure, serious side effects or contraindication to a majority (not more than 3) biosimilar product(s) is required (unless otherwise specified per applicable state regulations and/or there is data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs).
      [DOCUMENTATION REQUIRED: Document when the preferred biologic product or biosimilar was tried and the length of the trial period. Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache).]
      MOLINA REVIEWER NOTE: For Illinois Marketplace, please see Appendix.
      OR
   2. FOR INITIAL OR CONTINUATION OF THERAPY REQUESTS OF A PHYSICIAN ADMINISTERED MEDICATION: BIOSIMILAR DRUGS are preferred when requested as a physician administered drug per applicable state regulations and/or there is a lack of data demonstrating clinical superiority of reference drugs over the FDA approved biosimilar drugs. A reference medication is approved under the following conditions:
      a. Treatment with at least two associated biosimilar drug(s) has been ineffective, resulted in serious side effects, or is contraindicated (i.e., an allergic reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR an adverse reaction to a specific inactive ingredient in the preferred biologic product or biosimilar OR therapeutic success while taking a non-preferred biologic product or biosimilar and therapeutic failure while taking the preferred biologic product or biosimilar documented by patient diary or medical charted notes)

      [DOCUMENTATION REQUIRED: Document when the preferred biologic product or biosimilar was tried and the length of the trial period. Provide specific clinical documentation of therapeutic failure on the preferred biologic product or biosimilar whenever possible. Describe the medical problem caused by the preferred referenced biologic. Vague and non-descriptive symptoms are not adequate rationale (e.g., stomachache).]

B. HYPERCALCEMIA OF MALIGNANCY:
   1. Documented diagnosis of hypercalcemia of malignancy, defined as albumin-corrected serum calcium level greater than 12.5 mg/dL (3.1 mmol/L) dated within the past 30 days
      AND
   2. Documentation of trial and failure of or labeled contraindication to zoledronic acid 4 mg or pamidronate

C. GIANT CELL TUMOR OF BONE:
1. Documentation that member has a diagnosis of a giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity
AND
2. FOR MEMBERS AGES 12-17 YEARS ONLY:
   a. Member weighs at least 45kg
   AND
   b. Member has documented skeletal maturity defined by at least 1 mature long bone (e.g., closed epiphyseal growth plate of the humerus)

D. PREVENTION OF SKELETAL- RELATED EVENTS IN PATIENTS WITH MULTIPLE MYELOMA OR BONE METASTASES FROM SOLID TUMORS:
1. (a) Diagnosis of a solid tumor primary cancer (i.e., breast, bladder, kidney, ovarian, thyroid, prostate, lung cancer, etc.) AND evidence of ONE or more metastatic bone lesions.
OR
(b) Diagnosis of multiple myeloma

CONTINUATION OF THERAPY:

A. HYPERCALCEMIA OF MALIGNANCY:
1. Documentation of positive response to therapy with objective improvement in symptoms defined as albumin-corrected serum calcium level of 12.5 mg/dL or less
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

B. PREVENTION OF SKELETAL- RELATED EVENTS IN PATIENTS WITH MULTIPLE MYELOMA OR BONE METASTASES FROM SOLID TUMORS AND GIANT CELL TUMOR OF BONE:
1. Documented clinically significant improvements in the disease state, stability on the medication, or lack of disease progression
AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity

DURATION OF APPROVAL:

Hypercalcemia of Malignancy: Initial authorization: 3 months, Continuation of therapy: 12 months
Giant cell tumor of bone, Multiple Myeloma and Bone Metastases from a Solid Tumor: Initial Authorization: 12 months, Continuation of therapy: 12 months

PRESCRIBER REQUIREMENTS:

Prescribed by, or in consultation with, a board-certified endocrinologist, oncologist, or other applicable specialist. [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

GIANT CELL TUMOR OF BONE: 12 years of age and older
ALL OTHER INDICATIONS: 18 years of age and older

QUANTITY:

Hypercalcemia of malignancy: 120 mg every 4 weeks; during the first month, give an additional 120 mg on days 8 and 15
Giant cell tumor of bone: 120 mg once every 4 weeks; during the first month, give an additional 120 mg on days 8 and 15
Bone metastases from solid tumors: 120 mg every 4 weeks
Multiple myeloma: 120 mg every 4 weeks

PLACE OF ADMINISTRATION:
The recommendation is that injectable medications in this policy will be for pharmacy or medical benefit coverage and the subcutaneous injectable products administered in a place of service that is a non-hospital facility-based location.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:
Subcutaneous

DRUG CLASS:
RANK Ligand (RANKL) Inhibitors

FDA-APPROVED USES:
Indicated for prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors, 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, treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy.

Product	Interchangeable?
Xgeva (denosumab)	No
Aukelso (denosumab-kyqq)	No
Bilprevda (denosumab-nxxp)	No
Bomyntra (denosumab-bnht), denosumab-bnht	No
Jubereq (denosumab-desu)	No
Osenvelt (denosumab-bmwo)	No
Oziltus (denosumab-mobz)	Yes
Wyost (denosumab-bbdz)	Yes
Xbryk (denosumab-dssb), denosumab-dssb	No
Xtrenbo (denosumab-qbde)	No

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.

State Specific Information
State Marketplace

Illinois (Source: Illinois General Assembly)

"(215 ILCS 134/45.1) Sec. 45.1. Medical exceptions procedures required. (c) An off-formulary exception request shall not be denied if: (1) the formulary prescription drug is contraindicated; (2) the patient has tried the formulary prescription drug while under the patient's current or previous health insurance or health benefit plan and the prescribing provider submits evidence of failure or intolerance; or (3) the patient is stable on a prescription drug selected by his or her health care provider for the medical condition under consideration while on a current or previous health insurance or health benefit plan. (d) Upon the granting of an exception request, the insurer, health plan, utilization review organization, or other entity shall authorize the coverage for the drug prescribed by the enrollee's treating health care provider, to the extent the prescribed drug is a covered drug under the policy or contract up to the quantity covered. (e) Any approval of a medical exception request made pursuant to this Section shall be honored for 12 months following the date of the approval or until renewal of the plan."

A biosimilar is a highly similar version of a brand name biological drug that meets strict controls for structural, pharmaceutical, and clinical consistency. A biosimilar manufacturer must demonstrate that there are no meaningful clinical differences (i.e., safety and efficacy) between the biosimilar and the reference product. Clinical performance is demonstrated through human pharmacokinetic (exposure) and pharmacodynamic (response) studies, an assessment of clinical immunogenicity, and, if needed, additional clinical studies.[1]

As costs for biological specialty drugs continue to rise, the growing biosimilar market will benefit providers and patients by broadening biological treatment options and expanding access to these medications at lower costs. Molina Healthcare, Inc. continues to be committed to continually reevaluating preferred strategies and applying innovative cost-controls to ensure patients receive safe, effective, and quality healthcare. This commitment includes potentially creating a preference for biosimilars when value can be added without compromising patient satisfaction and safety.

1. Food and Drug Administration. Biosimilar and Interchangeable Products. Retrieved from https://www.fda.gov/drugs/biosimilars/biosimilar-and-interchangeable-products. Accessed October 8, 2019.

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:

Xgeva, a receptor activator of nuclear factor kappa-B ligand (RANKL) inhibitor, is indicated for the prevention of skeletal related events in patients with multiple myeloma and in patients with bone metastases from solid tumors. Xgeva is also indicated 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. Xgeva is also indicated for the treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. Another injectable formulation of denosumab is available, Prolia®, but it is not included in this policy. The prescribing information for Xgeva notes that patients receiving Xgeva should not take Prolia. Xgeva is available as a single-use vial that contains 120 mg of denosumab per 1.7 mL (70 mg/mL).

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:

All other uses of denosumab are considered experimental/investigational and therefore, will follow Molina's Off- Label policy. Contraindications to denosumab include: hypocalcemia, known clinically significant hypersensitivity to denosumab, pregnancy.

Exclusions/Discontinuation:

Do not use concurrently with bisphosphonates, with another RANKL inhibitor (i.e., use of same

active ingredient [Prolia or biosimilars]), or parathyroid hormone analogs or anabolic agents.

OTHER SPECIAL CONSIDERATIONS:
For appropriate indications, patients should be counseled to concurrently take calcium (1000 mg) and vitamin D (400-1200 international units) supplements in conjunction with denosumab.

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all- inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
J0897	Injection, denosumab,1mg
Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg
Q5157	Injection, denosumab-bmwo (stoboclo/osenvelt), biosimilar, 1 mg
Q5158	Injection, denosumab-bnht (bomyntra/conexxence), biosimilar, 1 mg

AVAILABLE DOSAGE FORMS:
Bilprevda SOLN 120MG/1.7ML
Bomyntra SOLN 120MG/1.7ML
Bomyntra SOSY 120MG/1.7ML
Osenvelt SOLN 120MG/1.7ML
Wyost SOLN 120MG/1.7ML
Xgeva SOLN 120MG/1.7ML single- dose vial

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3. Aukelso (denosumab-kyqq) injection, for subcutaneous use [prescribing information]. Cambridge, MA: Biobon Biologics Inc.; September 2025.
4. Bilprevda (denosumab-nxxp) injection, for subcutaneous use [prescribing information].

Jersey City, NJ: ORGANON & Co.; August 2025.
5. Bomyntra (denosumab-bnht) injection, for subcutaneous use [prescribing information]. Lake Zurich, IL: Fresenius Kabi USA, LLC; March 2025.
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SUMMARY OF REVIEW/REVISIONS	DATE
REVISION- Notable revisions: Products Affected Required Medical Information FDA-Approved Uses Appendix Contraindications/Exclusions/Discontinuation Coding/Billing Information Available Dosage Forms References	Q1 2026

REVISION- Notable revisions: Required Medical Information Continuation of Therapy References	Q1 2024
REVISION- Notable revisions: Required Medical Information Continuation of Therapy Prescriber Requirements Age Restrictions Place of Administration FDA-Approved Uses Contraindications/Exclusions/Discontinuation References	Q1 2023
Q2 2022 Established tracking in new format	Historical changes on file