

Clinical Policy: Cinacalcet (Sensipar)

Reference Number: CP.PHAR.61

Effective Date: 05.01.11

Last Review Date: 08.23

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Cinacalcet (Sensipar[®]) is a calcium-sensing receptor agonist.

FDA Approved Indication(s)

Sensipar is indicated for the treatment of:

- Secondary hyperparathyroidism (HPT) in adult patients with chronic kidney disease (CKD) on dialysis.
- Hypercalcemia in adult patients with parathyroid carcinoma (PC).
- Hypercalcemia in adult patients with primary HPT for whom parathyroidectomy would be indicated on the basis of serum calcium levels, but who are unable to undergo parathyroidectomy.

Limitation(s) of use: Sensipar is not indicated for use in patients with CKD who are not on dialysis.

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[®] that Sensipar is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Secondary Hyperparathyroidism (must meet all):

1. Diagnosis of secondary HPT due to CKD;
2. Prescribed by or in consultation with a nephrologist or endocrinologist;
3. Age \geq 18 years;
4. Member is on dialysis;
5. Lab results over the previous 3-6 months show trending increase in iPTH level or current (within the last 30 days) labs show iPTH above normal levels;
6. Failure of a vitamin D analog (*see Appendix B*) at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
7. Member is not receiving other calcimimetics;
8. At the time of request, member does not have serum calcium less than the lower limit of the normal range;
9. Dose does not exceed 300 mg per day.

Approval duration: 6 months

B. Parathyroid Carcinoma and Primary Hyperparathyroidism (must meet all):

1. Diagnosis of one of the following (a or b):
 - a. Hypercalcemia due to PC;
 - b. Hypercalcemia due to primary HPT;
2. Prescribed by or in consultation with an oncologist, nephrologist, or endocrinologist;
3. Age \geq 18 years;
4. Member is not receiving other calcimimetics;
5. Dose does not exceed either of the following (a and b):
 - a. 360 mg per day;
 - b. 4 tablets per day.

Approval duration: 6 months

C. 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 one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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 for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Approval

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

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy as evidenced by a decrease in iPTH (for secondary HPT) or a decrease in serum calcium (for PC or primary HPT), unless request is for a dose increase;
3. Member is not receiving other calcimimetics;
4. If request is for a dose increase, new dose does not exceed the following (a or b):
 - a. Secondary HPT: 300 mg per day;
 - b. PC and primary HPT (i and ii):
 - i. 360 mg per day;

- ii. 4 tablets per day.

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 one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
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 for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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. PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CKD: chronic kidney disease	iPTH: intact parathyroid hormone
FDA: Food and Drug Administration	PC: parathyroid carcinoma
HPT: hyperparathyroidism	

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
calcitriol (Rocaltrol [®])	Oral: 0.25 mcg PO QD or QOD; may increase dose by 0.25 mcg/day at 4 to 8 week intervals IV: 1 to 2 mcg/day IV 3 times weekly on approximately every other day; may increase by 0.5 to 1 mcg/dose at 2 to 4 week intervals	Oral: 1 mcg/day IV: 4 mcg/day
doxercalciferol (Hectorol [®])	Oral: 10 mcg PO 3 times weekly at dialysis; increase dose as needed at 8 week intervals in 2.5 mcg	Oral: 20 mcg 3 times weekly

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	increments if iPTH is not lowered by 50% and fails to reach the target range IV: 4 mcg IV bolus 3 times weekly at the end of dialysis, increase dose as needed at 8 week intervals by 1 to 2 mcg increments if iPTH is not lowered by 50% and fails to reach the target range	IV: 18 mcg/week
paricalcitol (Zemlar [®])	1 mcg PO daily if baseline iPTH level is 500 picog/mL or less; 2 mcg PO daily if baseline iPTH level is greater than 500 picog/mL; may titrate dose at 2 to 4 week intervals	0.24 mcg/kg

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): serum calcium is less than the lower limit of the normal range
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Secondary HPT	Starting dose: 30 mg PO QD Titrate no more frequently every 2-4 weeks through sequential doses of 30, 60, 90, 120, and 180 mg QD as necessary to achieve targeted iPTH levels	300 mg/day
Hypercalcemia in patients with PC or primary HPT	Starting dose: 30 mg PO BID Titrate every 2-4 weeks through sequential doses of 30 mg BID, 90 mg BID, and 90 mg TID or QID as necessary to normalize serum calcium levels	360 mg/day

VI. Product Availability

Tablets: 30 mg, 60 mg, 90 mg

VII. References

1. Sensipar Prescribing Information. Thousand Oaks, CA: Amgen, Inc.; December 2019. Available at: www.sensipar.com. Accessed April 12, 2023.
2. Kidney Disease: Improving Global Outcomes (KDIGO) CKD–MBD Work Group. KDIGO 2017 clinical practice guideline update for the diagnosis, evaluation, prevention, and treatment of chronic kidney disease–mineral and bone disorder (CKD–MBD). *Kidney International Supplements* 2017; 7:1–59. Available at: <http://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf>.
3. Bilezikian JP, Brandi ML, Eastell R, et al. Guidelines for the management of asymptomatic primary hyperparathyroidism: summary statement from the Fourth International Workshop. *J Clin Endocrinol Metab.* 2014; 99: 3561-3569.

4. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed May 24, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: added the requirement that Sensipar not be used concomitantly with any other calcimimetic agents for consistency with other policies addressing secondary HPT; increased maximum dose limit for secondary HPT to 300 mg/day, supported by Clinical Pharmacology; references reviewed and updated.	05.10.19	08.19
Revised positive response to therapy criterion to allow continuation of therapy if request is for dose increase.	11.19.19	02.20
3Q 2020 annual review: added Commercial LOB; references reviewed and updated.	04.28.20	08.20
3Q 2021 annual review: no significant changes; HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	05.10.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.17.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.12.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	04.12.23	08.23

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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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