

Clinical Policy: Conjugated Estrogens/Bazedoxifene (Duavee)

Reference Number: CP.PMN.258

Effective Date: 03.01.21

Last Review Date: 02.26

Line of Business: HIM, Medicaid

[Revision Log](#)

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

Description

Conjugated estrogens/bazedoxifene (Duavee[®]) is a combination of conjugated equine estrogens and an estrogen agonist/antagonist. The pairing of conjugated estrogens with bazedoxifene produces a composite effect that is specific to each target tissue. The bazedoxifene component reduces the risk of endometrial hyperplasia that can occur with the conjugated estrogens component.

FDA Approved Indication(s)

Duavee is indicated in women with a uterus for:

- Treatment of moderate-to-severe vasomotor symptoms associated with menopause.
- Prevention of postmenopausal osteoporosis.

Limitation(s) of use:

- Duavee should be used for the shortest duration consistent with treatment goals and risks for the individual woman. Postmenopausal women should be re-evaluated periodically as clinically appropriate to determine if treatment is still necessary.
- When prescribing solely for the prevention of postmenopausal osteoporosis, therapy should only be considered for women at significant risk of osteoporosis and non-estrogen medication should be carefully considered.

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 Duavee is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Vasomotor Symptoms (must meet all):

1. Diagnosis of vasomotor symptoms associated with menopause;
2. Member has not undergone a hysterectomy;
3. Failure of 2 formulary estrogen products (*not contraceptives, see Appendix B*), unless contraindicated or clinically significant adverse effects are experienced;*

**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*

4. Dose does not exceed both of the following (a and b):
 - a. 0.45 mg conjugated estrogens/20 mg bazedoxifene per day;
 - b. 1 tablet per day.

Approval duration: 12 months

B. Osteoporosis (must meet all):

1. Prescribed for the prevention of postmenopausal osteoporosis;
2. Member has not undergone a hysterectomy;
3. Failure of a 12-month trial of an oral bisphosphonate (*see Appendix B; generic alendronate is preferred*) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;*
**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
4. Failure of a 12-month trial of raloxifene, unless contraindicated or clinically significant adverse effects are experienced;*
**For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Dose does not exceed both of the following (a and b):
 - a. 0.45 mg conjugated estrogens/20 mg bazedoxifene per day;
 - b. 1 tablet per day.

Approval duration: 12 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: 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: 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: HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section 1 (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;

3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
 - a. 0.45 mg conjugated estrogens/20 mg bazedoxifene per day;
 - b. 1 tablet 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: 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: 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: 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 policy – 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

FDA: Food and Drug Administration

WHI: Women's Health Initiative

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
Estrogen Products		
estradiol (Alora [®] , Climara [®] , Divigel [®] , Elestrin [®] , Estrace [®] , EstroGel [®] , Evamist [®] , Menostar [®] , Minivelle [®] , Vivelle Dot [®])	Varies by formulation	Varies
Menest [®] (esterified estrogens)	0.3 to 1.25 mg PO QD	1.25 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Premarin [®] (conjugated estrogens)	0.3 mg PO QD; may titrate if needed	1.25 mg/day
Premphase [®] , Prempro [®] (conjugated estrogens/medroxyprogesterone)	1 tablet PO QD	1 tablet/day
Oral Bisphosphonates		
alendronate (Fosamax [®])	5 mg PO QD or 35 mg PO q week	5 mg/day or 35 mg/week
ibandronate (Boniva [®])	150 mg PO q month	150 mg/month
risedronate (Actonel [®])	5 mg PO QD or 35 mg PO q week or 75 mg PO QD for 2 consecutive days for 2 doses/month or 150 mg PO q month	5 mg/day or 35 mg/week or 150 mg/month
Selective Estrogen Receptor Modulators (SERMs)		
raloxifene (Evista [®])	60 mg PO QD	60 mg/day

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): undiagnosed abnormal uterine bleeding; known suspected or past history of breast cancer; known or suspected estrogen-dependent neoplasia; active or past history of venous thromboembolism; active or past history of arterial thromboembolism; hypersensitivity (angioedema, anaphylaxis) to estrogens, bazedoxifene, or any ingredients; known hepatic impairment or disease; known protein C, protein S, or antithrombin deficiency or other known thrombophilic disorders; pregnancy, women who may become pregnant, and nursing mothers
- Boxed warning(s): endometrial cancer, cardiovascular disorders, and probable dementia

Appendix D: General Information

- Duavee is not recommended for use in women greater than 75 years of age. An increased risk of probable dementia in women over 65 years of age was reported in the Women's Health Initiative (WHI) Memory ancillary studies of the WHI using daily conjugated estrogens (0.625 mg).
- Women taking Duavee should not take additional estrogens.
- There is an increased risk of endometrial cancer in a woman with a uterus who uses unopposed estrogens. Duavee has been shown to reduce the risk of endometrial hyperplasia, which may be a precursor to endometrial cancer.
- Estrogen therapy should not be used for the prevention of cardiovascular disease or dementia.
- The WHI estrogen-alone substudy reported increased risks of stroke and deep vein thrombosis (DVT) in postmenopausal women (50 to 79 years of age) during 7.1 years of treatment with daily oral conjugated estrogens (0.625 mg)-alone, relative to placebo.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Vasomotor symptoms, osteoporosis	1 tablet PO QD	1 tablet/day

VI. Product Availability

Tablet: 0.45 mg/20 mg

VII. References

1. Duavee Prescribing Information. Philadelphia, PA: Wyeth Pharmaceuticals Inc.; March 2024. Available at: www.duavee.com. Accessed October 13, 2025.
2. Camacho PM, Petak SM, Brinkley N et al. American Association of Clinical Endocrinologists/American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis-2020 update. *Endocr Pract.* 2020;26(1):1-46.
3. Shoback D, Rosen CJ, Black DM, et al. Pharmacological management of osteoporosis in postmenopausal women: an endocrine society guideline update. *J Clin Endocrinol Metab*; March 2020, 105(3): 587-594.
4. Eastell R, Rosen CJ, Black DM, et al. Pharmacological management of osteoporosis in postmenopausal women: An Endocrine Society Clinical Practice Guideline. *J Clin Endocrinol Metab*; 2019, 104: 1595–1622.
5. Stuenkel CA, Davis SR, Gompel A, et al. Treatment of the symptoms of the menopause: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2015; 100(11): 3975-4011.
6. Clinical Pharmacology [database online]. Tampa, FL: Elsevier; 2023. Available at: www.clinicalkeys.com/pharmacology.
7. Paccou J, Yavropoulou MP, Naciu AM, et al. Prevention and treatment of glucocorticoid-induced osteoporosis in adults: recommendations from the European Calcified Tissue Society. *Eur J Endocrinol.* 2024 Nov 27;191(6):G1-G17. doi: 10.1093/ejendo/lvae146.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.13.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.06.22	
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.02.22	02.23
1Q 2024 annual review: no significant changes; for osteoporosis initial criteria, added "generic" before alendronate to clarify that generic is preferred; for Appendix B, removed estropiate due to product unavailability and updated and updated dosing regimen; references reviewed and updated.	10.20.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	10.22.24	02.25
Added step therapy bypass for IL HIM per IL HB 5395.	09.16.25	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2026 annual review: no significant changes; revised initial approval duration from 6 to 12 months; references reviewed and updated.	10.13.25	02.26

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.

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