SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Yorvipath® (palopegteriparatide)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ____

Member Sentara #: ______________________ **Date of Birth:** ____________

Prescriber Name: ____

Prescriber Signature: ______________________________ **Date:** ____________

Office Contact Name: ____

Phone Number: ______________________ **Fax Number:** ____________________

NPI #: ____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: ____

Dosing Schedule: ______________________ **Length of Therapy**: ____________________

Diagnosis: ______________________ **ICD Code, if applicable:** ____________________

Weight (if applicable): ____________________ **Date weight obtained:** ____________________

Recommended Dosing:

- Starting dosage: 18 mcg once daily. Dosage adjustments should be made in 3 mcg increments or decrements. Do not increase the dosage more often than every 7 days or decrease the dosage more often than every 3 days. Maximum recommended dosage: 30 mcg subcutaneously once daily.

Quantity Limits:

- Maximum approval of 2 pens per 28 days (all strengths)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

- ❑ Member is 18 years of age or older
- ❑ Medication is prescribed by or in consultation with an endocrinologist

(Continued on next page)

- ❑ Member must have a confirmed diagnosis of chronic hypoparathyroidism (HP) lasting for at least 26 weeks, with documentation of **BOTH** of the following **(must submit medical chart notes and lab test results for documentation)**:
  - ❑ Symptomatic chronic hypocalcemia with low albumin-adjusted serum calcium levels or low ionized serum calcium despite compliance with active vitamin D and calcium supplementation
  - ❑ Undetectable or inappropriately low intact PTH (iPTH) measured with either a 2nd or 3rd generation assay on two occasions at least two weeks apart within the last 12 months
- ❑ Member does **NOT** have acute postsurgical hypoparathyroidism (chronic postsurgical hypoparathyroidism is now defined as lasting for at least 12 months after surgery)
- ❑ **ALL** the following lab test results have been submitted **(must submit test results obtained within the last 60 days)**:
  - ❑ Baseline 25-hydroxyvitamin D levels are within normal limits
  - ❑ Baseline albumin-adjusted serum calcium is ≥ 7.8 mg/dL
  - ❑ Baseline magnesium level is ≥ 1.3 mg/dL
  - ❑ Estimated glomerular filtration rate (eGFR) is ≥ 30 mL/min/1.73 m^2
  - ❑ Baseline TSH is within normal limits and members taking thyroid medications have been stable and compliant with medication for the last 5 weeks **(verified by pharmacy paid claims)**
- ❑ Member will **NOT** use any of the following while taking the prescribed medication: Natpara® (parathyroid hormone), teriparatide (Forteo®), abaloparatide (Tymlos®), cinacalcet (Sensipar®), etelcalcetide (Parsabiv®)
- ❑ Member does **NOT** have impaired responsiveness to PTH (pseudohypoparathyroidism) or any disease that might affect calcium metabolism, calcium-phosphate homeostasis, or PTH levels other than hypoparathyroidism

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member continues to meet **ALL** initial authorization criteria
- ❑ Member's albumin-adjusted serum calcium is maintained within normal limits **(must submit test results obtained within the last 60 days)**
- ❑ Member no longer requires active vitamin D or therapeutic doses of calcium (elemental calcium doses above 600 mg daily are considered therapeutic for this condition)
- ❑ Member has experienced disease response to treatment defined by improved or stabilized clinical signs/symptoms of hypoparathyroidism **(must submit medical chart notes or lab test results for documentation)**

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: **11/21/2024**
REVISED/UPDATED/REFORMATTED: 12/11/2024