

# SENTARA HEALTH PLANS

## 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<sup>®</sup> (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

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- ❑ 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  $\geq 7.8$  mg/dL
  - ❑ Baseline magnesium level is  $\geq 1.3$  mg/dL
  - ❑ Estimated glomerular filtration rate (eGFR) is  $\geq 30$  mL/min/1.73 m<sup>2</sup>
  - ❑ 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<sup>®</sup> (parathyroid hormone), teriparatide (Forteo<sup>®</sup>), abaloparatide (Tymlos<sup>®</sup>), cinacalcet (Sensipar<sup>®</sup>), etelcalcetide (Parsabiv<sup>®</sup>)
- ❑ 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.\****