

Request for Prior Authorization
Palopegteriparatide (Yorvipath)
(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # _ _ _ _ _ _ _ _ _ _ _ _ _ _	Patient name 	DOB
Patient address 		
Provider NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _	Prescriber name 	Phone
Prescriber address 		Fax
Pharmacy name 	Address 	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI _ _ _ _ _ _ _ _ _ _ _ _ _ _	Pharmacy fax 	NDC _ _ _ _ _ _ _ _ _ _ _ _ _ _

Prior authorization (PA) is required for palopegteriparatide (Yorvipath). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of chronic hypoparathyroidism; and
3. Patient has had an inadequate response to maximally tolerated oral calcium and vitamin d analog (e.g., calcitriol) therapy; and
4. Documentation of baseline lab results (attach results obtained within 2 weeks prior to starting therapy) for:
 - a. Serum 25 hydroxyvitamin D (25(OH)D) level within the normal range (20 to 80 ng/mL); and
 - b. Albumin-corrected serum calcium level ≥ 7.8 g/dL; and
5. Is prescribed by or in consultation with an endocrinologist or nephrologist.

If criteria for coverage are met, initial requests will be given for 6 months. Additional authorizations will be considered at 12-month intervals with:

1. Documentation of a positive response to therapy, as evidenced by normalized albumin-corrected serum calcium level of 8.3 to 10.6 g/dL (attach lab results).

Non-Preferred

☐ Yorvipath

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

Has patient had an inadequate response to maximally tolerated oral calcium and vitamin D analog therapy?

☐ Yes (document trials):

Oral calcium trial: Strength/ Dose: Trial dates:

Vitamin D analog trial: Strength/Dose: Trial dates:

☐ No

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Baseline lab results (attach results obtained within 2 weeks prior to starting therapy)

Serum 25 hydroxyvitamin D (25(OH)D) level: _____ Date obtained: _____

Albumin-corrected serum calcium level: _____ Date obtained: _____

Is prescriber an endocrinologist or nephrologist?

☐ **Yes, document specialty:** _____

☐ **No** If no, note consultation with specialist:

Consultation Date: _____ Physician Name, Specialty & Phone: _____

Renewal Requests

Document positive response to therapy, as evidenced by normalized albumin-corrected serum calcium level of 8.3 to 10.6 g/dL (attach results).

Albumin-corrected serum calcium level: _____ Date obtained: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.