IOWA Health and Human Services

Request for Prior Authorization
Palopegteriparatide (Yorvipath)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(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

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.*