

**YORVIPATH
(palopegterlparatide)**

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Hypoparathyroidism

AND ALL of the following:

1. Inadequate treatment response, intolerance, or contraindication to conventional therapy (e.g., oral calcium and/or calcitriol)
2. Albumin-corrected serum calcium ≥ 7.8 mg/dL prior to initiation of therapy
3. Serum 25-hydroxyvitamin D level is within the normal range prior to initiation of therapy
4. **NO** acute post-surgical hypoparathyroidism (within 6 months of surgery)
5. Prescriber agrees to monitor for hypercalcemia and hypocalcemia
6. One injection will be used to achieve the once daily recommended dosage

Prior - Approval Limits

Quantity 6 prefilled pens* per 84 days

*Each prefilled pen contains 14 doses

Duration 12 months

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Hypoparathyroidism



**BlueCross
BlueShield**

Federal Employee Program.

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AND ALL of the following:

1. Prescriber agrees to monitor for hypercalcemia and hypocalcemia
2. One injection will be used to achieve the once daily recommended dosage

Prior - Approval *Renewal* Limits

Same as above