

This document applies to the following:

Formulary	Applies
Standard Control (SF)	<input type="checkbox"/>
Standard Control – Choice (SCCF)	<input type="checkbox"/>
Preferred Drug Plan Design (PDPD)	<input type="checkbox"/>
Advanced Control Specialty (ACSF)	<input type="checkbox"/>
Advanced Control Specialty – Choice (ACSCF)	<input type="checkbox"/>
Managed Medicaid Template (MMT)	<input type="checkbox"/>
Marketplace (MF)	<input checked="" type="checkbox"/>
Aetna Small Group Affordable Care Act (SG ACA)	<input checked="" type="checkbox"/>
Aetna Health Exchange (AHE)	<input checked="" type="checkbox"/>
Aetna Individual Lives (IVL)	<input checked="" type="checkbox"/>
Value (VF)	<input type="checkbox"/>

Formulary	Applies
New to Market (NTM)	<input type="checkbox"/>
Standard Formulary Chart (SFC)	<input type="checkbox"/>
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	<input type="checkbox"/>
Advanced Control Specialty Formulary Chart (ACSFC)	<input type="checkbox"/>
Value Formulary Chart (VFC)	<input type="checkbox"/>
Medical Benefit	<input type="checkbox"/>
Medical Benefit: Advanced Biosimilars First	<input type="checkbox"/>
Medical Benefit: Managed Medicaid (MMMB)	<input type="checkbox"/>
Medicare Part B	<input type="checkbox"/>
Medicare Part B: Advanced Biosimilars First	<input type="checkbox"/>

# Exceptions Criteria

## Osteoporosis

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Marketplace (MF), Aetna Individual Lives (IVL), Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE).

## Plan Design Summary

This program applies to the osteoporosis products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred product and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to all members requesting treatment with Forteo, Teriparatide (branded generic), or generic teriparatide. This program applies to members who are initiating a new treatment regimen with Evenity.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

## Table. Osteoporosis Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

Reference number(s)
3284-D

	Product(s)
Preferred	<ul style="list-style-type: none"> <li>Tymlos (abaloparatide)</li> </ul>
Target	<ul style="list-style-type: none"> <li>Evenity (romosozumab-aqqg)</li> <li>Forteo (teriparatide)</li> <li>Teriparatide (branded generic)</li> <li>teriparatide (generic)</li> </ul>

## Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

Coverage for a targeted product is provided when any of the following criteria is met:

- There is documentation that the member is currently undergoing treatment with the targeted product Evenity, and coverage is required to complete the current course of treatment.
- Member will be using the targeted product Forteo, Teriparatide (branded generic), or generic teriparatide for treatment of glucocorticoid-induced osteoporosis.
- Member has a documented inadequate response, intolerable adverse event, or contraindication to the preferred product Tymlos (e.g., cumulative treatment with Tymlos exceeding 24 months in a patient's lifetime).

## References

- Evenity [package insert]. Thousand Oaks, CA: Amgen Inc.; April 2024.
- Forteo [package insert]. Indianapolis, IN: Lilly USA, LLC; July 2024.
- Teriparatide [package insert]. Morristown, NJ: Alvogen, Inc.; November 2023.
- Teriparatide [package insert]. Weston, FL: Apotex Corp.; January 2023.
- Tymlos [package insert]. Boston, MA: Radius Health, Inc.; December 2023.