



PRIOR AUTHORIZATION REQUEST

Yorvipath

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

☐ Initial (If checked, go to 6)

☐ Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication?
[If no, skip to question 6.]

Yes No

If you have any
questions, call:
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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 6.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of response include reduction in the patient's oral calcium dose, reduction in the patient's active vitamin D dose, and maintenance of a stable albumin-corrected total serum calcium concentration.] [No further questions.]	Yes	No
6	What is the indication? ☐ Chronic Hypoparathyroidism (If checked, go to 7) ☐ Other (If checked, no further questions)		
7	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
8	Has documentation been submitted to confirm that the patient has a pretreatment low albumin-corrected serum calcium less than or equal to 8.5 milligrams per deciliter OR has an ionized serum calcium greater than 4.4 milligrams per deciliter within the last 4 weeks at baseline before the requested medication? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm that the patient has a pretreatment undetectable or inappropriately low intact parathyroid concentration less than 20 picograms per milliliter, by second- or third-generation immunoassay, on AT LEAST TWO occasions? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been submitted to confirm that the patient has had treatment failure with AT LEAST TWO formulary oral products for AT LEAST 3 months EACH unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [Note: Treatment failure will be assessed using prescription claim history and follow up lab work to confirm supplements were ineffective. Formulary options include but are not limited to: calcium tablets, calcitriol capsules, and calcium citrate-vitamin D tablets 200 milligrams-6.25 micrograms.]	Yes	No

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[If no, no further questions.]

11	Has documentation been submitted to confirm that the patient has sufficient baseline 25-hydroxyvitamin D stores between 20 to 80 nanograms per milliliter OR 49 to 200 nanomoles per liter within the last 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has a serum magnesium level between 1.5 to 2.2 milligrams per deciliter within the last 3 months? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has the patient been evaluated to rule out other conditions? [Note: Examples include acute post-surgical hypoparathyroidism, pseudohypoparathyroidism, or hypoparathyroidism caused by calcium-sensing reception (CaSR mutations).] [If no, no further questions.]	Yes	No
14	Is the patient at an increased risk of osteosarcoma? [Note: Examples include open epiphyses, metabolic bone disease including Paget's disease, bone metastasis or a history of skeletal malignancies, hereditary disorders predisposing to osteosarcoma, and/or history of external beam or implant radiation therapy involving the skeleton.] [If yes, no further questions.]	Yes	No
15	Will the patient be treated concomitantly with ANY of the following: A) Loop diuretics, B) Phosphate binders (other than calcium supplements), C) Digoxin, D) Lithium, E) Methotrexate, F) Biotin greater than 30 micrograms per day, OR G) Systemic corticosteroids (other than as replacement therapy)? [If yes, no further questions.]	Yes	No
16	Has documentation been submitted to confirm that the patient has had treatment failure with teriparatide for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Is the requested medication prescribed by or in consultation with an endocrinologist or nephrologist? [If no, no further questions.]	Yes	No
18	Does the prescribed dosing exceed Food and Drug Administration (FDA) approved indication? [Dosing 18 micrograms once daily. Dose adjusted based on daily active vitamin D or calcium doses.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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