

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1464-1
Program	Prior Authorization/Notification
Medication	Yorvipath [®] (palopegteriparatide)
P&T Approval Date	12/2024
Effective Date	3/1/2025

1. Background:

Yorvipath[®] is a parathyroid hormone analog (PTH(1-34)) indicated for the treatment of hypoparathyroidism in adults.

Limitations of Use:

- Yorvipath was not studied for acute post-surgical hypoparathyroidism.
- Titration scheme was only evaluated in adults who first achieved an albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment.

2. Coverage Criteria^a:

<p>A. <u>Initial Authorization</u></p> <p>1. Yorvipath will be approved based on all of the following criteria:</p> <p style="padding-left: 40px;">a. Diagnosis of hypoparathyroidism</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 40px;">b. Yorvipath is not being used to treat <i>acute</i> post-surgical hypoparathyroidism</p> <p style="text-align: center;">-AND-</p> <p style="padding-left: 40px;">c. Patient has achieved an albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D (e.g., calcitriol) treatment</p> <p style="text-align: center;">Authorization will be issued for 12 months</p> <p>B. <u>Reauthorization</u></p> <p>1. Yorvipath will be approved based on the following criterion:</p> <p style="padding-left: 40px;">a. Documentation of positive clinical response to Yorvipath therapy</p> <p style="text-align: center;">Authorization will be issued for 12 months</p> <p>^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization</p>
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management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Medical Necessity may be in place

4. References:

1. Yorvipath[®] [package insert]. Princeton, NJ: Ascendis Pharma, Inc.; August 2024.

Program	Prior Authorization/Notification - Yorvipath (palopegteriparatide)
Change Control	
12/2024	New program.