Clinical Policy Title:	palopegteriparatide
Policy Number:	RxA.893
Drug(s) Applied:	Yorvipath
Original Policy Date:	04/15/2025
Last Review Date:	04/10/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hypoparathyroidism (must meet all):

1. Diagnosis of chronic hypoparathyroidism;
2. Trial and failure of ≥ 6 weeks of both of the following, unless contraindicated or clinically significant adverse effects are experienced (a and b):
   a. Calcitriol;
   b. calcium carbonate or calcium citrate;
3. Recent serum 25 (OH) vitamin D in normal range (20-50 ng/mL) and albumin-adjusted serum calcium ≥ 7.8 mg/dL;

Approval Duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Hypoparathyroidism (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy with RxAdvance initial approval.

Approval duration

All Lines of Business (except Medicare): 12 months

References

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	04/15/2025	04/10/2025

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

© 2025 RxAdvance Corporation. All rights reserved. This policy contains the confidential and proprietary information of RxAdvance. Unauthorized reproduction, distribution, modification, display, storage, transmission, or use of this policy or any information contained herein is strictly prohibited.