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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION YORVIPATH® (palopegteriparatide)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page).

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 6-months approval:

1. Is Yorvipath prescribed by or in consultation with a specialist in the area of the member's diagnosis (e.g., endocrinologist, nephrologist)?
   ☐ Yes ☐ No
2. Is the member 18 years of age or older?
   ☐ Yes ☐ No
3. Does the member have a diagnosis of hypoparathyroidism?
   ☐ Yes ☐ No
4. Does the member have acute post-surgical hypoparathyroidism, pseudohypoparathyroidism, or hypoparathyroidism caused by calcium-sensing receptor (CaSR) mutations?
   ☐ Yes ☐ No
5. Does the member have baseline albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment?
   ☐ Yes ☐ No
6. Does the member have baseline vitamin D levels above the lower limit of normal?
   ☐ Yes ☐ No
7. Has the member tried and had an inadequate response to maximally tolerated calcium and vitamin D supplements (e.g., calcitriol, ergocalciferol, cholecalciferol)?
   ☐ Yes ☐ No
8. Will the member continue calcium and vitamin D supplementation while titrating to an appropriate dose of Yorvipath?
   ☐ Yes ☐ No
9. Is the member using Yorvipath in combination with any bisphosphonate (e.g., alendronate, ibandronate, risedronate), denosumab, estrogen, raloxifene, and Sensipar (cinacalcet) for the requested indication?
   ☐ Yes ☐ No

(Form continued on next page).

Member's Last Name: **Member's First Name:**

For renewal, complete the following questions to receive a 1-year approval:

10. Does the member continue to meet the above criteria and have an albumin-corrected total serum calcium concentration between 8.3 to 10.6 mg/dL?
    ☐ Yes ☐ No
11. Does the member continue to experience clinical benefit from the requested treatment?
    ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.