STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

TERIPARATIDE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
TERIPARATIDE	FORTEO, TERIPARATIDE	24700		GPI-10 (3004407000)	

GUIDELINES FOR USE

1. Is the medication being used for **ONE** of the following diagnoses?
   - Postmenopausal osteoporosis
   - Primary or hypogonadal osteoporosis in a male patient
   - Glucocorticoid-induced osteoporosis

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

2. Does the patient meet **ONE** of the following criteria?
   - The patient is at high risk for fractures defined as **ONE** of the following:
     - History of osteoporotic (i.e., fragility, low trauma) fracture(s)
     - 2 or more risk factors for fracture (e.g., history of multiple recent low trauma fractures, BMD T-score less than or equal to -2.5, corticosteroid use, or use of GnRH analogs such as Synarel [nafarelin])
     - No prior treatment for osteoporosis **AND** FRAX score ≥ 20% for any major fracture OR ≥ 3% for hip fracture
   - The patient is unable to use oral therapy (i.e., upper gastrointestinal [GI] problems - unable to tolerate oral medication, lower GI problems - unable to absorb oral medications, trouble remembering to take oral medications or coordinating an oral bisphosphonate with other oral medications or their daily routine)
   - The patient had a trial of, intolerance to, or a contraindication to a bisphosphonate (e.g., Fosamax [alendronate], Actonel [risedronate], Boniva [ibandronate])

   If yes, continue to #3.
   If no, do not approve.
   DENIAL TEXT: See the denial text at the end of the guideline.

3. Has the patient received a total of 24 months cumulative treatment with Forteo (teriparatide)?

   If yes, continue to #4.
   If no, **approve the requested drug up to 24 months lifetime cumulative treatment duration by GPID or GPI-14 with the following quantity limits:**
   - **Forteo 600mcg/2.4mL: #2.4mL per 28 days.**
   - **Teriparatide 620mcg/2.48mL: #2.48mL per 28 days.**

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GUIDELINES FOR USE (CONTINUED)

4. Does the patient remain at or has returned to having a high risk for fracture?

If yes, **approve the requested drug up to 12 months by GPID or GPI-14 with the following quantity limits:**

- **Forteo 600mcg/2.4mL: #2.4mL per 28 days.**
- **Teriparatide 620mcg/2.48mL: #2.48mL per 28 days.**

If no, do not approve.
DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **TERIPARATIDE (Forteo)** requires the following rule(s) be met for approval:

A. You have ONE of the following diagnoses:
   1. Postmenopausal osteoporosis (a type of joint condition)
   2. Primary or hypogonadal (sex organs don't function properly) osteoporosis in a male patient
   3. Glucocorticoid (steroid)-induced osteoporosis

B. You meet ONE of the following:
   1. You are at high risk for fractures defined as ONE of the following:
      a. History of osteoporotic (i.e., fragility, low trauma) fracture(s)
      b. Two or more risk factors for fracture (such as history of multiple recent low trauma fractures, bone marrow density (BMD) T-score less than or equal to -2.5, corticosteroid use, or use of GnRH analogs such as Synarel [nafarelin])
      c. No prior treatment for osteoporosis AND FRAX (test for your risk of fractures) score of at least 20 percent for any major fracture OR at least 3 percent for hip fracture
   2. You are unable to use oral therapy due to reasons such as upper gastrointestinal [GI] problems - unable to tolerate oral medication, lower GI problems - unable to absorb oral medications, trouble remembering to take oral medications or coordinating an oral bisphosphonate with other oral medications or their daily routine
   3. You had a trial of, intolerance (side effect), or contraindication (harmful for) to a bisphosphonate (such as Fosamax [alendronate], Actonel [risedronate], Boniva [ibandronate])

C. You meet ONE of the following:
   1. You have received a total of 24 months of cumulative treatment with Forteo (teriparatide) AND remain at or have returned to having a high risk for fracture
   2. You have received less than 24 months of cumulative treatment

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Forteo and Teriparatide.

REFERENCE

- Forteo [Prescribing Information]. Indianapolis, IN.: Eli Lilly and Company; April 2021.
- Teriparatide [Prescribing Information]. Morristown, NJ.: Alvogen, Inc; October 2019.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 04/17/23
Created: 05/03
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P&T Approval: 01/22