Parathyroid Hormone Analog for Osteoporosis Prior Authorization with Quantity Limit Program Summary

This program applies to Medicaid.

Prior authorization applies to Teriparatide and Tymlos only. Quantity limits apply to Teriparatide, Tymlos, and Forteo.

For Medicaid, the preferred product is the MN Medicaid Preferred Drug List (PDL) preferred drug: Forteo.

The BCBS MN Step Therapy Supplement also applies to this program for Medicaid.

POLICY REVIEW CYCLE

Effective Date	Date of Origin
02-01-2024	12-01-2017

FDA APPROVED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Forteo® (teriparatide [recombinant])* Injection solution	Treatment of postmenopausal women with osteoporosis at high risk for fracture (defined herein as having a history of osteoporotic fracture or multiple risk factors for fracture) or who have failed or are intolerant to other available osteoporosis therapy Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy Use of Forteo for more than 2 years during a patient's lifetime should only be considered if a patient remains at or has returned to having a high risk of fracture.	*Generic equivalent available	1
Teriparatide Injection solution	Treatment of postmenopausal women with osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to 5 mg or greater of prednisone) at high risk for fracture, defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy		3
Tymlos®	Treatment of postmenopausal women with osteoporosis at high risk for fracture (defined as a history of osteoporotic fracture or multiple risk		2

Agent(s)	FDA Indication(s)	Notes	Ref#
(abaloparatide) Injection solution	factors for fracture), or patients who have failed or are intolerant to other available osteoporosis therapy To increase bone density in men with osteoporosis at high risk for fracture (defined as a history of osteoporotic fracture or multiple risk factors for fracture), or patients who have failed or are intolerant to other available osteoporosis therapy.		

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

Postmenopausal Osteoporosis	The American Association of Clinical Endocrinologists/American College of Endocrinology joint guidelines for postmenopausal osteoporosis state that there are several pathways to diagnose osteoporosis. • T-score -2.5 or below in the lumbar spine, femoral neck, total proximal femur or distal 1/3 of the radius • Low-trauma spine or hip fracture (regardless of bone mineral density) • T-score between -1.0 and -2.5 and a fragility fracture of proximal humerus, pelvis, or distal forearm • T-score between -1.0 and -2.5 and high FRAX (Fracture Risk Assessment Tool) (or if available, TBS [trabecular bone score]-adjusted FRAX) fracture based on country-specific thresholds T-scores represent the number of standard deviations from the normal young-adult mean values, and are used for diagnostic classification in postmenopausal women. However, Bone Mineral Density (BMD) testing is not intended as a treatment threshold. BMD should be combined with other clinical risk factors for fractures for accurate assessment of fracture risk and to guide treatment decisions. The World Health Organization (WHO) has defined t-score criteria as follows: • Normal: -1.0 or above • Osteopenia: T-score between -1.0 and -2.5 • Osteoporosis: T-score at or below -2.5 • Severe or established osteoporosis: -2.5 or below with fragility fracture(5)
Very High Risk Postmenopausal Women	The 2020 American Association of Clinical Endocrinology (AACE) Guidelines created a 'very high' risk category for post-menopausal women with osteoporosis. The following patients are considered to be a very high fracture risk: • Patients with a recent fracture (within the past 12 months), fractures while on approved osteoporosis therapy multiple fractures, or fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), • Patients with a very low T-score (less than -3.0), • Patients with a high risk for falls or history of injurious falls, • Patients with very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or other validated fracture risk algorithm. Patients who have been diagnosed with osteoporosis but do not meet the above definition of very high fracture risk are to be considered to be at high risk. The AACE recommends alendronate, denosumab, risedronate, and zoledronate as appropriate initial therapy for most osteoporotic patients with high fracture risk. Abaloparatide, denosumab, romosozumab, teriparatide, and zoledronate should be considered for patients unable to use oral therapy and as initial therapy for patients at very high fracture risk.(6)

Male Osteoporosis	The Endocrine Society recommends pharmacological treatment for men aged 50 or older at high risk of fracture including, but not limited to: • Men who have had a hip or vertebral fracture without major trauma • Men who have not experienced a spine or hip fracture, but whose BMD of the spine, femoral neck, and/or total hip is 2.5 standard deviations below the mean of normal young white males • In the US, men who have a T-score between -1.0 and -2.5 in the spine, femoral neck, or total hip plus a 10-year risk of hip fracture greater than or equal to 3% using FRAX. For men outside the US, region-specific guidelines should be considered • Men who are receiving long-term glucocorticoid therapy in pharmacological doses Men at high risk of fracture can be treated with medication approved by regulatory agencies such as the U.S. FDA or the European Medicines Agency (EMA). At the time of this writing of the 2012 Endocrine Society clinical practice guideline for Osteoporosis in Men, alendronate, risedronate, zoledronic acid, and teriparatide were recommended. Denosumab can also be used for men receiving ADT [androgen deprivation therapy] for prostate cancer. The selection of therapeutic agent should be individualized based on factors including fracture history, severity of osteoporosis (T-scores), the risk for hip fracture, patterns of BMD, comorbid conditions, cost, and other factors.(10) The American College of Physicians (ACP) recommends bisphosphonates to reduce the risk for vertebral fracture in men who have clinically recognized osteoporosis.(11)
Treatment	According to the National Osteoporosis Foundation, postmenopausal women and men age 50 and older presenting with the following should be considered for treatment: • A hip or vertebral fracture • T-score of -2.5 or lower at the femoral neck, total hip, or lumbar spine (or at the 33% radius site if necessary) • Low bone mass (T-score between -1 and -2.5) and a 10-year probability of a hip fracture greater than or equal to 3% or a 10-year probability of a major osteoporosis-related fracture greater than or equal to 20% based on the US-adapted WHO algorithm(3) The Endocrine Society also agrees with these treatment thresholds for men with increased fracture risk.(10) In their 2020 Postmenopausal Osteoporosis Guidelines, the AACE stated that osteoporosis can be diagnosed if there is a fragility fracture in the absence of other metabolic bone disease, independent of the T-score. Thus, patients with a T-score indicating osteopenia, but who have had a fragility fracture of the spine, hip, proximal humerus, pelvis, or distal forearm should be diagnosed with osteoporosis and considered for pharmacologic therapy.(6)
Glucocorticoid-Induced Osteoporosis	Oral bisphosphonates are currently regarded as the first line option for adults 40 years of age or over receiving long-term glucocorticoids that are at high risk for fracture, based on available population fracture data. Other options include IV bisphosphonates, parathyroid hormone/parathyroid hormone-related peptide, and denosumab. The American College of Rheumatology defines high risk of fracture as: adults aged greater than or equal to 40 years, previous osteoporotic fracture, hip or spine BMD T-score less than or equal to -2.5-, or 10- year fracture risk of greater than or equal to 20% (major osteoporotic fracture or greater than or equal to 3% (hip fracture).(8) Until the effect of concomitant use of osteoporosis agents is better understood, the AACE does not recommend concomitant use of agents for osteoporosis.(4)
Safety	Teriparatide carries the following boxed warnings:(3) • In rats, teriparatide caused an increase in the incidence of osteosarcoma, a malignant bone tumor.

	• Because of the uncertain relevance of the rat osteosarcoma finding to humans, prescribe teriparatide only for patients for whom potential benefits outweigh potential risk. • Teriparatide should not be prescribed for patients at increased baseline risk for osteosarcoma (e.g., those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton). In 2020, Forteo received a labeling update regarding length of therapy. Use of Forteo for more than 2 years during a patient's lifetime should only be considered if a patient remains at or has returned to having a high risk for fracture. The boxed warning for osteosarcoma was also removed at that time. Of note, these changes were in the Forteo brand label only, and did not occur in Teriparatide.(1,3)

REFERENCES

Number	Reference
1	Forteo Prescribing Information. Eli Lilly & Co. Indianapolis, IN. April 2021.
2	Tymlos Prescribing Information. Radius Health, Inc. December 2022.
3	Teriparatide Prescribing Information. Alvogen, Inc. November 2019
4	Reference no longer used
5	Cosman F, de Beur SJ, LeBoff MS, et. al. Clinician's Guide to Prevention and Treatment of Osteoporosis. National Osteoporosis Foundation, Osteoporosis Int 25:2359-2381, 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4176573/pdf/198_2014_Article_2794.pdf
6	Camacho PM, Petak SM, Binkley N, et al. American Association of Clinical Endocrinologists and American College of Endocrinology clinical practice guidelines for the diagnosis and treatment of postmenopausal osteoporosis – 2020 Update. https://www.endocrinepractice.org/action/showPdf?pii=S1530-891X%2820%2942827-7
7	Reference no longer used
8	Reference no longer used
9	Miller PD, Hattersley G, Juel Riis B, et al. Effect of abaloparatide vs. placebo on new vertebral fractures in postmenopausal women with osteoporosis. JAMA. 2016;316(7):722-733. https://jamanetwork.com/journals/jama/fullarticle/2544640
10	Endocrine Society Guideline: Osteoporosis in Men: An Endocrine Society Clinical Practice Guideline 2012. https://academic.oup.com/jcem/article/97/6/1802/2536476
11	Qaseem A, Forciea MA, McLean RM, et. al. Treatment of Low Bone Density or Osteoporosis to Prevent Fractures in Men and Women: A Clinical Practice Guideline Update from the American College of Physicians. Ann Intern Med. 2017;166:818-839. https://annals.org/aim/fullarticle/2625385/treatment-low-bone-density-osteoporosis-prevent-fractures-men-women-clinical
12	Buckley L, Guyatt G, Fink HA, et al. 2017 American College of Rheumatology guideline for the prevention and treatment of glucocorticoid-induced osteoporosis. Arthritis and Rheumatology Vol. 69, No. 8, August 2017, pp 1521–1537. https://onlinelibrary.wiley.com/doi/full/10.1002/art.40137
13	Compston, J. Glucocorticoid-induced osteoporosis: an update. Endocrine 2018; 61(1):7-16. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5997116/

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Tymlos	Abaloparatide Subcutaneous Soln Pen-injector 3120 MCG/1.56ML	3120 MCG/1.56ML	M ; N ; O ; Y	N		
	Teriparatide (Recombinant) Soln Pen-inj 620 MCG/2.48ML	620 MCG/2.48ML	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	Teriparatide (Recombinant) Soln Pen-inj 620 MCG/2.48ML	620 MCG/2.48ML	1	Pen	28	DAYS			
Forteo	Teriparatide (Recombinant) Soln Pen-inj 600 MCG/2.4ML	600 MCG/2.4ML	1	Pen	28	DAYS			
Tymlos	Abaloparatide Subcutaneous Soln Pen-injector 3120 MCG/1.56ML	3120 MCG/1.56ML	1	Pen	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	Teriparatide (Recombinant) Soln Pen-inj 620 MCG/2.48ML	620 MCG/2.48ML	Medicaid
Tymlos	Abaloparatide Subcutaneous Soln Pen-injector 3120 MCG/1.56ML	3120 MCG/1.56ML	Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	Teriparatide (Recombinant) Soln Pen-inj 620 MCG/2.48ML	620 MCG/2.48ML	Medicaid
Forteo	Teriparatide (Recombinant) Soln Pen-inj 600 MCG/2.4ML	600 MCG/2.4ML	Medicaid
Tymlos	Abaloparatide Subcutaneous Soln Pen-injector 3120 MCG/1.56ML	3120 MCG/1.56ML	Medicaid

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Teriparatide through preferred	**For Medicaid, the preferred product is the MN Medicaid Preferred Drug List (PDL) preferred drug: Forteo** **Non-Preferred Agent(s) Teriparatide** will be approved when ALL of the following are met: 1. ONE of the following:

Module	Clinical Criteria for Approval
	A. The patient has a diagnosis of osteoporosis AND ALL of the following: 1. ONE of the following: A. The patient's sex is male and ONE of the following: 1. The patient's age is 50 years or over **OR** 2. The prescriber has provided information that the requested agent is medically appropriate for the patient's age and sex **OR** B. The patient's sex is female and ONE of the following: 1. The patient is postmenopausal **OR** 2. The prescriber has provided information that the requested agent is medically appropriate for the patient's sex and menopause status **AND** 2. The patient's diagnosis was confirmed by ONE of the following: A. A fragility fracture in the hip or spine **OR** B. A T-score of -2.5 or lower **OR** C. A T-score of -1.0 to -2.5 and ONE of the following: 1. A fragility fracture of a proximal humerus, pelvis, or distal forearm **OR** 2. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% **OR** 3. A FRAX 10-year probability of hip fracture of greater than or equal to 3% **AND** 3. ONE of the following: A. The patient is at a very high fracture risk as defined by ONE of the following: 1. Patient had a recent fracture (within the past 12 months) **OR** 2. Patient had fractures while on FDA approved osteoporosis therapy **OR** 3. Patient has had multiple fractures **OR** 4. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) **OR** 5. Patient has a very low T-score (less than -3.0) **OR** 6. Patient is at high risk for falls or has a history of injurious falls **OR** 7. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm **OR** B. ONE of the following: 1. The patient's medication history includes a bisphosphonate AND ONE of the following: 1. The patient has had an inadequate response to bisphosphonate therapy (medical records required) **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over bisphosphonates **OR** 2. The patient has an intolerance or hypersensitivity to a bisphosphonate (medical records required) **OR** 3. The patient has an FDA labeled contraindication to ALL bisphosphonates (medical records required) **OR** 4. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND** 2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND**

Module	Clinical Criteria for Approval
	3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 5. The prescriber has provided documentation that ALL bisphosphonates cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **OR** B. The patient has a diagnosis of glucocorticoid-induced osteoporosis AND ALL of the following: 1. The patient is either initiating or currently taking glucocorticoids in a daily dosage equivalent to 5 mg or higher of prednisone **AND** 2. The patient's expected current course of therapy of glucocorticoids is for a period of at least 3 months **AND** 3. The patient's diagnosis was confirmed by ONE of the following: A. A fragility fracture in the hip or spine **OR** B. A T-score of -2.5 or lower **OR** C. A T-score of -1.0 to -2.5 and ONE of the following: 1. A fragility fracture of a proximal humerus, pelvis, or distal forearm **OR** 2. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% **OR** 3. A FRAX 10-year probability of hip fracture of greater than or equal to 3% **AND** 4. ONE of the following: A. The patient is at a very high fracture risk as defined by ONE of the following: 1. Patient had a recent fracture (within the past 12 months) **OR** 2. Patient had fractures while on FDA approved osteoporosis therapy **OR** 3. Patient has had multiple fractures **OR** 4. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) **OR** 5. Patient has a very low T-score (less than -3.0) **OR** 6. Patient is at high risk for falls or has a history of injurious falls **OR** 7. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm **OR** B. ONE of the following: 1. The patient's medication history includes a bisphosphonate AND ONE of the following: 1. The patient has had an inadequate response to bisphosphonate therapy (medical records required) **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over bisphosphonates **OR** 2. The patient has an intolerance or hypersensitivity to a bisphosphonate (medical records required) **OR** 3. The patient has an FDA labeled contraindication to ALL bisphosphonates (medical records required) **OR** 4. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND**

Module	Clinical Criteria for Approval
	2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** 3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 5. The prescriber has provided documentation that ALL bisphosphonates cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 2. ONE of the following: 1. The requested agent is a preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) **OR** 2. The request is for a non-preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) and ONE of the following: 1. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND** 2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** 3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 2. The patient has tried and had an inadequate response to two preferred chemically unique agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) as indicated by BOTH of the following: 1. ONE of the following: 1. Evidence of a paid claim(s) **OR** 2. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) **AND** B. ONE of the following: 1. The required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over the prerequisite/preferred agent(s) **OR** 3. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) that is not expected to occur with the requested agent **OR** 4. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 3. The patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg or another parathyroid hormone analog (e.g., abaloparatide) **AND** 4. The patient does NOT have any FDA labeled contraindications to the requested agent **AND** 5. ONE of the following: A. The patient has never received treatment with a parathyroid hormone analog (Teriparatide, Forteo, and Tymlos) **OR** B. The patient has been previously treated with parathyroid hormone analog(s) AND the total duration of treatment with Forteo (teriparatide), Teriparatide, and Tymlos (abaloparatide) has NOT exceeded 24 months in lifetime

Module	Clinical Criteria for Approval
	Length of approval: up to a total of 2 years of treatment in lifetime between Teriparatide and Tymlos (abaloparatide). Only one parathyroid hormone analog will be approved for use at a time. NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.
Tymlos through preferred	**For Medicaid, the preferred product is the MN Medicaid Preferred Drug List (PDL) preferred drug: Forteo** **Non-Preferred Agent(s) Tymlos** will be approved when ALL of the following are met: 1. The patient has a diagnosis of osteoporosis AND ALL of the following: A. ONE of the following: 1. The patient's sex is male and ONE of the following: A. The patient's age is 50 years or over **OR** B. The prescriber has provided information that the requested agent is medically appropriate for the patient's age and sex **OR** 2. The patient's sex is female and ONE of the following: A. The patient is postmenopausal **OR** B. The prescriber has provided information that the requested agent is medically appropriate for the patient's sex and menopause status **AND** B. The patient's diagnosis was confirmed by ONE of the following: 1. A fragility fracture in the hip or spine **OR** 2. A T-score of -2.5 or lower **OR** 3. A T-score of -1.0 to -2.5 and ONE of the following: A. A fragility fracture of a proximal humerus, pelvis, or distal forearm **OR** B. a FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% **OR** C. a FRAX 10-year probability of hip fracture of greater than or equal to 3% **AND** C. ONE of the following: 1. The patient is at a very high fracture risk as defined by ONE of the following: A. Patient had a recent fracture (within the past 12 months) **OR** B. Patient had fractures while on FDA approved osteoporosis therapy **OR** C. Patient has had multiple fractures **OR** D. Patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) **OR** E. Patient a very low T-score (less than -3.0) **OR** F. Patient is at high risk for falls or has a history of injurious falls **OR** G. Patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm **OR** 2. ONE of the following: A. The patient's medication history includes a bisphosphonate AND ONE of the following: 1. The patient has had an inadequate response to bisphosphonate therapy (medical records required) **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over bisphosphonates **OR** B. The patient has an intolerance or hypersensitivity to bisphosphonate (medical records required) **OR**

Module	Clinical Criteria for Approval
	C. The patient has an FDA labeled contraindication to ALL bisphosphonates (medical records required) **OR** D. The patient is currently being treated with the requested agent as indicated by ALL of the following: 1. A statement by the prescriber that the patient is currently taking the requested agent **AND** 2. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** 3. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** E. The prescriber has provided documentation that ALL bisphosphonates cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 2. ONE of the following: A. The requested agent is a preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) **OR** B. The request is for a non-preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) and ONE of the following: 1. The patient is currently being treated with the requested agent as indicated by ALL of the following: A. A statement by the prescriber that the patient is currently taking the requested agent **AND** B. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent **AND** C. The prescriber states that a change in therapy is expected to be ineffective or cause harm **OR** 2. The patient has tried and had an inadequate response to two preferred chemically unique agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) as indicated by BOTH of the following: A. ONE of the following: 1. Evidence of a paid claim(s) **OR** 2. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) **AND** B. ONE of the following: 1. The required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event **OR** 2. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over the prerequisite/preferred agent(s) **OR** 3. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) that is not expected to occur with the requested agent **OR** 4. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **AND** 3. The patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog (e.g., teriparatide) therapy **AND** 4. The patient does NOT have any FDA labeled contraindications to the requested agent **AND**

Module	Clinical Criteria for Approval
	5. The total duration of treatment with Forteo (teriparatide), Teriparatide, and Tymlos (abaloparatide) has NOT exceeded 2 years in lifetime **Length of approval:** For those who have had less than 2 years of treatment in lifetime between Teriparatide, and Tymlos (abaloparatide), approve for the remainder of the 2 years of therapy remaining. Only one parathyroid hormone analog will be approved for use at a time. NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
QL with PA Forteo, Teriparatide	**Quantity Limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **Length of approval:** up to a total of 2 years of treatment in lifetime between Teriparatide and Tymlos (abaloparatide); Approve for up to 2 years for new Forteo starts or patients new to the plan's Prior Authorization process. Approve for 1 year if patient has already had 2 years of Forteo in lifetime and is at high risk. Only one parathyroid hormone analog will be approved for use at a time.
QL with PA Tymlos through preferred	**Quantity Limit for the Target Agent(s)** will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **Length of approval:** For those who have had less than 2 years of treatment in lifetime between Teriparatide and Tymlos (abaloparatide), approve for the remainder of the 2 years of therapy remaining. Only one parathyroid hormone analog will be approved for use at a time.