MEDICATION POLICY

Generic Name: Teriparatide

Therapeutic Class or Brand Name: Forteo®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 12/13/17

GPI Code: 3004407000

Prior Authorization Criteria (may be considered medically necessary when criteria I through III are met):

I. Documented diagnosis of one of the following conditions A through C:
   A. Postmenopausal female patients with osteoporosis.
   B. Male patients with primary or hypogonadal osteoporosis.
   C. Female and male patients with osteoporosis likely caused by systemic glucocorticoid therapy.

II. Patient must be at high risk for fracture defined by meeting either criterion 1 or 2:
   1. Have a bone mineral density that is 2.5 or more standard deviations below that of a "young normal" adult (T-score at or below –2.5).
   2. Have osteopenia (T-score between -1 and -2.5) and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5 mg per day of prednisone (or equivalent).

III. Documented trial and failure of (following a 24 month treatment period), intolerance to, or contraindication to at least one bisphosphonate (i.e. alendronate, etidronate, ibandronate, risedronate, zoledronic acid, etc.).

Exclusion Criteria:

- Patients with Paget's disease of bone.
- Pediatric or young adult patients with open epiphyses.
- Patients with prior external beam or implant radiation therapy involving the skeleton.
- Patients with bone metastases, history of skeletal malignancies, metabolic bone diseases other than osteoporosis, or hypercalcemic disorders.
- Use of Forteo® for more than 2 years during a patients' lifetime.

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- One 2.4mL prefilled injectable pen per 28 days.

Approval Length:

- **Authorization:** 24 months with no renewal option.
- **Re-Authorization:** N/A

Appendix:

N/A

References:

1. https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Forteo.pdf.
2. http://blue.regence.com/trgmedpol/drugs/dru085.pdf.
3. Medi-Span.
4. http://uspl.lilly.com/forteo/forteo.html#pi.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
12/13/2017	1. Policy reviewed: no changes made.
10/6/2016	1. **Updated** "http://pi.lilly.com/us/forteo-pi.pdf" **to** "http://uspl.lilly.com/forteo/forteo.html#pi" **under References**.
4/15/2015	1. **Changed** "Documented trial and failure of (following a 24 month treatment period), intolerance to, or contraindication to at least one bisphosphonate (i.e. alendronate, etidronate, and ibandronate)" **to** "Documented trial and failure of (following a 24 month treatment period), intolerance to, or contraindication to at least one bisphosphonate (i.e. alendronate, etidronate, ibandronate, risedronate, zoledronic acid, etc.)" **under Prior Authorization Criteria**. 2. **Added** "Patients with Paget's disease of bone"**,** "Patients with prior external beam or implant radiation therapy involving the skeleton"**,** "Patients with bone metastases, history of skeletal malignancies, metabolic bone diseases other than osteoporosis, or hypercalcemic disorders"**, and** "Use of Forteo® for more than 2 years during a patients' lifetime" **under Exclusion Criteria**. 3. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Forteo.pdf" **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Forteo.pdf" **under References**.
12/21/2013	1. **Adapted policy to new format.** 2. **Added GPI code**. 3. **Updated references** to include Medi-Span.