Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines:
Parathyroid Hormones

Effective: February 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Bonsity (teriparatide), Forteo (teriparatide) and **Teriparatide (teriparatide)** Injection is recombinant human parathyroid hormone analog indicated:

- **Increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture**
  To increase 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 glucocorticoid-induced osteoporosis at high risk for fracture**
  For the 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
- **Treatment of postmenopausal women with osteoporosis at high risk for fracture**
  For 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. In postmenopausal women with osteoporosis, Forteo (teriparatide) reduces the risk of vertebral and nonvertebral fractures

Tymlos (abaloparatide) is a human parathyroid hormone related peptide analog indicated:

- **Treatment of postmenopausal women with osteoporosis at high risk for fracture**
  For 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. In postmenopausal women with osteoporosis, Tymlos (abaloparatide) reduces the risk of vertebral and nonvertebral fractures.
- **Treatment to increase bone density in men with osteoporosis at high risk for fracture**
  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.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Bonsity, Forteo, Teriparatide, or Tymlos for patients when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documentation of **one (1)** of the following:
   a. T-score less than or equal to -2.5
   b. T-score of less than or equal to -1.0 and greater than -2.5 and the prescriber determines the patient is at high risk for fracture

c. FRAX score of 10-year risk of major osteoporotic fracture ≥20% or a risk of hip fracture ≥3%
d. One or more osteoporotic fracture

AND

2. Documentation of **one (1)** of the following:
    a. Documentation of inadequate response to, or inability to tolerate at least one of the traditional osteoporosis treatments (e.g., alendronate, calcitonin, denosumab, ibandronate, raloxifene, risedronate, zoledronic acid)
    b. Contraindication to all traditional osteoporosis treatments (e.g., alendronate, calcitonin, denosumab, ibandronate, raloxifene, risedronate, zoledronic acid)
    c. The patient is at very high risk for fracture (e.g., T-score of ≤-3.0 in the absence of fragility fracture[s], T-score of ≤-2.5 plus a fragility fracture [fracture from a low energy trauma excludes stress fracture, hand/foot fractures], or multiple fractures)
    d. The patient is new to the plan and stable on the requested agent prior to enrollment

Reauthorization Criteria

1. Documentation the patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of requested Parathyroid Hormone product

Limitations

1. Initial authorization of requested Parathyroid Hormone product is 24 months. Reauthorization of requested Parathyroid Hormone product will be provided in 12-month intervals.

Codes

None

References

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Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

1. September 12, 2023: No changes.
2. August 13, 2024: Added Reauthorization Criteria to clarify approval duration beyond initial 24 months of a Parathyroid Hormone product (eff 11/1/24).
3. July 8, 2025: Effective 10/1/25, updated coverage criteria to add patients at very high risk for fracture. Added criterion for contraindications to prerequisite trial. Removed criterion for history of low-trauma osteoporotic fracture.
4. January 13, 2026: Added Bonsity to the Medical Necessity Guideline with coverage criteria aligned with Forteo, Teriparatide, and Tymlos. Administrative update to remove Tufts Health Plan Commercial products (including CareLink) from the Medical Necessity Guideline template. (eff 2/1/26)
5. February 2026: Administrative update to add Tufts Health Plan Commercial products back to Medical Necessity Guideline template.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document

will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.