Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Yorvipath® (palopegteriparatide)

Effective: March 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

Yorvipath (palopegteriparatide) is a parathyroid hormone analog indicated for the treatment of hypoparathyroidism in adults.

Yorvipath has not been studied for acute post-surgical hypoparathyroidism. The titration scheme for Yorvipath was only evaluated in adults who first achieved an albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment.

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Yorvipath for Members when **ALL** of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of chronic hypoparathyroidism defined as six months or more

AND

2. Prescribed by or in consultation with an endocrinologist

AND

3. Documentation of **one (1)** of the following:
    a. Yorvipath is prescribed as an adjunct to calcium supplements and active forms of vitamin D
    b. Contraindication to calcium supplements and active forms of vitamin D

AND

4. Provider attestation the patient's disease cannot be adequately controlled on conventional therapy (calcium supplements and active vitamin D) alone

AND

5. Documentation of all of the following in a recent (within the last 30 days) lab results:
    a. Serum 25-hydroxyvitamin D concentration is within normal laboratory limits (30-100 ng/mL)
    b. Albumin-corrected serum calcium is greater than or equal to 7.8 mg/dL
    c. Serum magnesium level is within normal laboratory limits (1.7 to 2.2 mg/dL)

AND

6. The patient is 18 years of age or older

Reauthorization Criteria

1. Documented diagnosis of chronic hypoparathyroidism defined as six months or more

AND

2. Prescribed by or in consultation with an endocrinologist

AND

3. The patient is 18 years of age or older

AND

4. Documentation the patient has experienced a therapeutic response defined as maintained or normalized calcium levels compared to baseline

Limitations

1. Initial approval by the plan will be limited to 6 months. Reauthorization will be provided in 12-month intervals.
2. Members new to the plan stable on Yorvipath should be reviewed against Reauthorization Criteria.
3. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.

Codes

None

References

1. Brandi ML, et al. Management of hypoparathyroidism: Summary statement and guidelines. The Journal of Clinical Endocrinology & Metabolism. 2016 Jun;101(6):2273-83.
2. Khan AA, et al. Management of hypoparathyroidism. Journal of Bone and Mineral Research. 2022 Dec; 37(12):2663-77.
3. Khan AA, et al. Evaluation and management of hypoparathyroidism summary statement and guidelines from the second international workshop. Journal of Bone and Mineral Research. 2022 Dec;37(12):2568-85.
4. Yorvipath (palopegteriparatide) [package insert]. Hellerup, Denmark: Ascendis Pharma Bone Diseases A/S: October 2025.

Approval And Revision History

January 14, 2025: Reviewed by the Pharmacy & Therapeutics Committee. Medical Necessity Guideline effective February 1, 2025.

Subsequent endorsement date(s) and changes made:

- February 10, 2026: no changes.
- February 2026: Administrative update to remove CareLink from 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.