PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

9/16/2025

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Yorvipath - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Yorvipath - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Yorvipath (palopegteriparatide)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported? Y N

[If yes, no further questions.]

2.	Is the requested medication for the treatment of acute post-surgical hypoparathyroidism?	Y N
	[If yes, no further questions.]	
3.	Has the patient first achieved an albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
4.	Will the requested medication be used concurrently with another parathyroid (PTH) analog (e.g., teriparatide)?	Y N
	[If yes, no further questions.]	
5.	Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	Y N
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
	[If no, skip to question 8.]	
6.	Is there documentation showing the patient has experienced a positive clinical response, evidenced by reduction in dose or discontinuation of active vitamin D and/or calcium?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, no further questions.]	
7.	Is there documentation showing the patient has experienced a positive clinical response, evidenced by maintenance of albumin-adjusted serum calcium within normal range (8.3-10.6 mg/dL)?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
8.	Does the patient have diagnosis of chronic hypoparathyroidism of postsurgical, autoimmune, genetic, or idiopathic etiologies for at least 6 months?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Is there documentation supporting the diagnosis by showing BOTH of the following: A) Pretreatment low albumin-corrected serum calcium (i.e., less than or equal to 8.5 mg/dL) confirmed on at least two occasions separated by at least 2 weeks, and B) Pretreatment undetectable or inappropriately low intact parathyroid (PTH) concentration (i.e., greater than 20 pg/mL) on at least two occasions?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	

10. Is there documentation showing patient is currently on adequate calcium and active vitamin D (e.g., calcitriol) supplemental therapy as evidenced by both of the following: A) albumin-corrected serum calcium: 7.8-10.6 mg/dL, and B) serum 25-hydroxy vitamin D: 20-80 ng/mL?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Is the patient 18 years of age or older?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date