

TRICARE Prior Authorization Request Form for  
palopegteriparatide (**Yorvipath**)



**JOHNS HOPKINS**  
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

## USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

**Step 1** Please complete patient and physician information (please print):

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID # _____	Phone #: _____
Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

1. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Is the requested drug being prescribed by, or in consultation with, an endocrinologist?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Does the patient have a diagnosis of chronic hypoparathyroidism; based on hypocalcemia in the setting of inappropriately low serum parathyroid hormone (PTH) levels?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Can the patient be well-controlled on calcium supplements and active forms of vitamin D?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 5
5. Does the patient have an albumin-corrected serum calcium concentration greater than or equal to 7.8 mg/dL at baseline OR ionized serum calcium greater than or equal to 4.4 mg/dL at baseline?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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6. Does the patient have acute post-surgical hypoparathyroidism?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No <b>Sign and date below</b>
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**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date

[12 Feb 2025]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: