Clinical Policy Title:	parathyroid hormone
Policy Number:	RxA.244
Drug(s) Applied:	Natpara®
Original Policy Date:	02/07/2020
Last Review Date:	10/19/2023
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Hypocalcemia Secondary to Hypoparathyroidism (must meet all):

1. Diagnosis of hypocalcemia secondary to hypoparathyroidism;
2. Prescribed by or in consultation with an endocrinologist;
3. Age ≥ 18 years;
4. Natpara® is prescribed as an adjunct to calcium supplements and active forms of vitamin D, unless contraindicated;
5. Recent (dated within the last 30 days) serum calcium level is > 7.5 mg/dL;
6. Recent (dated within the last 30 days) lab result shows sufficient 25-hydroxyvitamin D stores [≥ 50 nmol/L (≥ 20 ng/mL)];
7. Trial and failure of a 12-week trial of calcium supplements and active forms of vitamin D (e.g., calcitriol) at up to maximally indicated doses, unless contraindicated or clinically significant adverse events are experienced;
   *Prescriber must indicate that the hypocalcemia is not well controlled with calcium supplements and active forms of vitamin D.
8. Dose does not exceed 100 mcg per day.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Hypocalcemia Secondary to Hypoparathyroidism (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. Recent (dated within the last 90 days) serum calcium level is within 8-9 mg/dL;
   b. Recent serum calcium level is > 9 mg/dL, and Natpara® dose is being decreased;
3. If request is for a dose increase, new dose does not exceed 100 mcg per day.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

References
Not Applicable

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Clinical Policy Title was updated. 2. Drug(s) Applied was updated. 3. Line of Business Policy Applies to was update to all lines of business. 4. Continued Therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been by RxAdvance..." 5. Initial Approval criteria: Commercial and Medicaid approval duration were updated from member's renewal date to 6 months. 6. Continued Approval criteria: Commercial and Medicaid approval duration were updated from member's renewal date to 6 months.	07/23/2020	09/14/2020
Policy was reviewed: 1. Abbreviated forms updated to full forms.	03/10/2021	06/10/2021