HARVARD PILGRIM HEALTH CARE
RECOMMENDED MEDICATION REQUEST GUIDELINES

TERIPARATIDE (FORTEO)

Generic	Brand	HICL	GCN	Exception/Other
TERIPARATIDE	FORTEO	24700		

GUIDELINES FOR USE

1. Is the request for a patient at high risk for osteoporotic bone fracture as evidenced by the presence of ONE or more of the following?
   - One or more recent low trauma bone fractures (includes sacral insufficiency fractures)
   - T-score of -3.5 or below
   - Low bone mineral density with a T-score of -2.5 or below with additional risk factors (e.g., prior osteoporotic fracture, Rheumatoid Arthritis)
   - Previously tried and failed a 6-month course of therapy with an alternative medication for osteoporosis (e.g., bisphosphonate (alendronate, ibandronate, risedronate, zoledronic acid 5mg/100mL), calcitonin, raloxifene or denosumab)

   If yes, continue to #2.
   If no, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Teriparatide (Forteo) guideline, Forteo is only covered if you are at high risk for an osteoporotic bone fracture as evidenced by one of the following:
   - A recent low trauma bone fracture
   - T-score of -3.5 or below
   - Low bone mineral density with a T-score of -2.5 or below with additional risk factors
   - Previously tried and failed a 6-month course of therapy with an alternative medication for osteoporosis.

   Your provider did not indicate that you meet one of these conditions and therefore your request was not approved.

2. Has the patient completed a 24-month course of Forteo therapy (as stated on MRF or evidenced in patient profile)?

   If yes, do not approve. Please use status code #238 and the denial text provided.
   DENIAL TEXT: Per your health plan's Teriparatide (Forteo) guideline, your plan covers 24 months of therapy per lifetime. Our records indicate that you have already received 24 months of coverage of teriparatide (Forteo) therapy and therefore your request was not approved.
   If no, continue to #3.

3. **Approve for up to two years by HICL with a fill count of up to 26.** (**PAC NOTE:** Please ensure approval time and fill count do not exceed two years based on MRF or patient profile. Do not approve for more than 24 months.). (The quantity limit is hard coded: one prefilled pen per 28 days.). Please use status code #056 and the approval text provided.
   APPROVAL TEXT: Your request has been approved for your condition for a maximum of one prefilled pen per 28-day supply for a **[enter months approved]** period.

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RATIONALE

To ensure that Forteo is not being used first line and that patients have tried and failed other bone modifying agents before its use. Forteo is contraindicated in patients who have a history of hypercalcemia, hyperparathyroidism, skeletal malignancy, Paget's disease, or are receiving radiation therapy and should not be used in these patients.

FDA APPROVED INDICATIONS

Forteo is indicated for postmenopausal women with osteoporosis who are at high risk for fracture and men with primary or hypogonadal osteoporosis who are at high risk for fracture and for men or women with Glucocorticoid-Induced osteoporosis at high risk for fracture.

REFERENCES

- Forteo Product Information. Eli Lilly. Available at www.forteohcp.com. October, 2016.
- National Osteoporosis Foundation. Clinician's Guide to Prevention and Treatment of Osteoporosis. Washington, DC: National Osteoporosis Foundation; August 2014. Accessed July 11, 2016.
- Management of osteoporosis in postmenopausal women: 2010 position statement of The North American Menopause Society. *Menopause*. 2010; 17(1):25-54.

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