



Parathyroid Hormone Analog Osteoporosis Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date 02-15-2026 **Date of Origin**

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Tymlos	abaloparatide subcutaneous soln pen-injector	3120 MCG/1.56ML	M ; N ; O ; Y	N		
Bonsity ; Forteo ; Teriparatide	teriparatide soln pen-inj	560 MCG/2.24ML	M ; N ; O ; Y	N ; O ; Y		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Bonsity ; Forteo ; Teriparatide	teriparatide soln pen-inj	560 MCG/2.24ML	2.24	mLs	28	DAYS	2.24 mL = 1 injection		
Tymlos	abaloparatide subcutaneous soln pen-injector	3120 MCG/1.56ML	1.56	mLs	30	DAYS	1.56 mLs = 1 injection		

ADDITIONAL QUANTITY LIMIT INFORMATION

Wildcard	Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Additional QL Information	Targeted NDCs When Exclusions Exist	Effective Date	Term Date
3004407000D216	Bonsity ; Forteo ; Teriparatide	teriparatide soln pen-inj	560 MCG/2.24ML	2.24 mL = 1 injection		03-27-2025	
3004400500D2	Tymlos	abaloparatide subcutaneous soln pen-injector	3120 MCG/1.56ML	1.56 mLs = 1 injection			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Bonsity ; Forteo ; Teriparatide	teriparatide soln pen-inj	560 MCG/2.24ML	Balanced ; Balanced Biosimilar ; Basic ; Basic

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Tymlos	abaloparatide subcutaneous soln pen-injector	3120 MCG/1.56ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Bonsity ; Forteo ; Teriparatide	teriparatide soln pen-inj	560 MCG/2.24ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Tymlos	abaloparatide subcutaneous soln pen-injector	3120 MCG/1.56ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
FORTEO, Bonsity, Teriparatide	<p>Forteo, Bonsity, Teriparatide will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has a diagnosis of osteoporosis and ALL of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient's sex is male and ONE of the following: <ol style="list-style-type: none"> 1. The patient's age is 50 years or over OR 2. The requested agent is medically appropriate for the patient's age and sex OR B. The patient's sex is female and ONE of the following: <ol style="list-style-type: none"> 1. The patient is postmenopausal OR 2. The requested agent is medically appropriate for the patient's sex and menopause status AND 2. The patient's diagnosis was confirmed by ONE of the following: <ol style="list-style-type: none"> A. A fragility fracture in the hip or spine OR B. A T-score of -2.5 or lower OR C. A T-score of -1.0 to -2.5 and ONE of the following: <ol style="list-style-type: none"> 1. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR 2. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% OR 3. A FRAX 10-year probability of hip fracture of greater than or equal to 3% AND 3. The patient has ONE of the following: <ol style="list-style-type: none"> A. A very high fracture risk as defined by ONE of the following: <ol style="list-style-type: none"> 1. Has had a recent fracture (within the past 12 months) OR 2. Has had fractures while on FDA labeled osteoporosis therapy OR 3. Has had multiple fractures OR 4. Has had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR 5. Has a very low T-score (less than -3.0) OR 6. Is at high risk for falls or has a history of injurious falls OR 7. Has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR B. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following:

Module	Clinical Criteria for Approval
	<ul style="list-style-type: none"> A. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR B. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND <ul style="list-style-type: none"> 2. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. Tried and had an inadequate response to a bisphosphonate (medical records required) OR 3. Has an intolerance or hypersensitivity to a bisphosphonate (medical records required) OR 4. Has an FDA labeled contraindication to ALL bisphosphonates (medical records required) OR <ul style="list-style-type: none"> B. The patient has a diagnosis of glucocorticoid-induced osteoporosis AND ALL of the following: <ul style="list-style-type: none"> 1. Is either initiating or currently taking glucocorticoids in a daily dosage equivalent to 5 mg or higher of prednisone AND 2. The patient's expected current course of therapy of glucocorticoids is for a period of at least 3 months AND 3. ONE of the following: <ul style="list-style-type: none"> A. The patient is less than 40 years of age AND has ONE of the following: <ul style="list-style-type: none"> 1. A prior fracture OR 2. Either initiating or currently taking glucocorticoids that is equivalent to a prednisone dose that is greater than or equal to 30 mg/day OR 3. Either initiating or currently taking glucocorticoids that is equivalent to a cumulative prednisone dose of greater than or equal to 5 g/year OR B. The patient is 40 years of age or greater AND has one of the following: <ul style="list-style-type: none"> 1. A prior osteoporotic fracture OR 2. A T-score of less than or equal to -2.5 OR 3. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% OR 4. A FRAX 10-year risk probability for hip fracture of greater than or equal to 3% OR 5. Either initiating or currently taking glucocorticoids that is equivalent to a prednisone dose that is greater than or equal to 30 mg/day for greater than 30 days OR 6. Either initiating or currently taking glucocorticoids that is equivalent to a cumulative prednisone dose of greater than or equal to 5 g/year OR C. Tried and had an inadequate response to a bisphosphonate (medical records required) OR D. Has an intolerance or hypersensitivity to a bisphosphonate (medical records required) OR E. Has an FDA labeled contraindication to ALL bisphosphonates (medical records required) AND 2. The patient has ONE of the following:

Module	Clinical Criteria for Approval
	<p>A. The request is for a BCBS IL Fully Insured, ASO Cost/BBF, HIM, or Non-ERISA ASO/Self-insured Municipalities/Counties member OR</p> <p>B. Is currently being treated with the requested agent and the patient is currently stable on the requested agent [chart notes are required] OR</p> <p>C. Tried and had an inadequate response to Forteo generic equivalent OR</p> <p>D. Forteo generic equivalent was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes are required] OR</p> <p>E. Has an intolerance or hypersensitivity to Forteo generic equivalent that is NOT expected to occur with the requested agent OR</p> <p>F. Has an FDA labeled contraindication to Forteo generic equivalent that is NOT expected to occur with the requested agent OR</p> <p>G. Has an intolerance or hypersensitivity to Forteo generic equivalent that is NOT expected to occur with the requested agent OR</p> <p>H. Has an FDA labeled contraindication to Forteo generic equivalent that is NOT expected to occur with the requested agent OR</p> <p>I. Forteo generic equivalent is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient’s adherence of care; OR worsen a comorbid condition; OR decrease the patient’s ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm [chart notes are required] OR</p> <p>J. Forteo generic equivalent is not in the best interest of the patient based on medical necessity [chart notes are required] OR</p> <p>K. Has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as the generic equivalent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event [chart notes are required] OR</p> <p>L. There is support for the use of the requested brand agent over the Forteo generic equivalent AND</p> <p>3. The patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg or another parathyroid hormone analog for osteoporosis (e.g., abaloparatide) AND</p> <p>4. The patient does NOT have any FDA labeled contraindications to the requested agent AND</p> <p>5. ONE of the following:</p> <p>A. The total duration of treatment with parathyroid hormone analog(s) for osteoporosis has NOT exceeded 2 years in a lifetime OR</p> <p>B. The total duration of treatment with parathyroid hormone analog(s) for osteoporosis has exceeded 2 years in a lifetime AND the patient is at high risk of fracture (e.g., shown by T-score, FRAX score, continued use of glucocorticoids at a daily equivalent of 5 mg of prednisone or higher)</p> <p>Length of Approval:</p> <p><u>BCBSOK</u>: 36 months</p> <p><u>BCBSIL and BCBSMT</u>: 12 months</p> <p><u>ALL other plans:</u></p> <p>For those who have not yet received a total of 2 years of treatment in their lifetime between Forteo (teriparatide), Bonsity, Teriparatide, and Tymlos (abaloparatide), approve for up to the remainder of that 2 year therapy which has not yet been received. [Approve at least 3 months for BCBSNM/BCBSMT]</p>

Module	Clinical Criteria for Approval
	<p>For those who have already received a total of 2 years of treatment in their lifetime between Forteo (teriparatide), Bonsity, or Teriparatide AND is at high risk of fracture, approve for up to 1 year. [Approve at least 3 months for BCBSNM/BCBSMT]</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following: <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. The requested indication is a rare disease AND C. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 2. ALL of the following: <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>
Tymlos	<p>Tymlos will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of osteoporosis and ALL of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> A. The patient's sex is male and ONE of the following: <ol style="list-style-type: none"> 1. The patient's age is 50 years or over OR 2. The requested agent is medically appropriate for the patient's age and sex OR

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	<p>B. The patient's sex is female and ONE of the following:</p> <ol style="list-style-type: none"> 1. The patient is postmenopausal OR 2. The requested agent is medically appropriate for the patient's sex and menopause status AND <p>B. The patient's diagnosis was confirmed by ONE of the following:</p> <ol style="list-style-type: none"> A. A fragility fracture in the hip or spine OR B. A T-score of -2.5 or lower OR C. A T-score of -1.0 to -2.5 and ONE of the following: <ol style="list-style-type: none"> 1. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR 2. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% OR 3. A FRAX 10-year probability of hip fracture of greater than or equal to 3% AND <p>C. The patient has ONE of the following:</p> <ol style="list-style-type: none"> A. A very high fracture risk as defined by ONE of the following: <ol style="list-style-type: none"> 1. Has had a recent fracture (within the past 12 months) OR 2. Has had fractures while on FDA labeled osteoporosis therapy OR 3. Has had multiple fractures OR 4. Has had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR 5. Has a very low T-score (less than -3.0) OR 6. Is at high risk for falls or has a history of injurious falls OR 7. Has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR B. ONE of the following: <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration OR 2. Tried and had an inadequate response to a bisphosphonate (medical records required) OR 3. Has an intolerance or hypersensitivity to a bisphosphonate (medical records required) OR 4. Has an FDA labeled contraindication to ALL bisphosphonates (medical records required) AND <ol style="list-style-type: none"> 2. The patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg or another parathyroid hormone analog for osteoporosis (e.g., teriparatide) AND 3. The patient does NOT have any FDA labeled contraindications to the requested agent AND 4. The total duration of treatment with Teriparatide, Bonsity, Forteo (teriparatide) and Tymlos (abaloparatide) has NOT exceeded 2 years in a lifetime <p>Length of Approval:</p>

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	<p>BCBSOK: 36 months BCBSIL and BCBSMT: 12 months</p> <p><u>ALL other plans</u>: up to the remainder of 2 years of treatment in a lifetime between Forteo (teriparatide), Bonsity, Teriparatide, and Tymlos (abaloparatide) [Approve at least 3 months for BCBSNM/BCBSMT]</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following: <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. The requested indication is a rare disease AND C. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 2. ALL of the following: <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>

Module	Clinical Criteria for Approval
Tymlos - preferred	<p>Tymlos will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed OR B. The patient has a diagnosis of osteoporosis AND ALL of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient's sex is male and ONE of the following: <ol style="list-style-type: none"> 1. The patient's age is 50 years or over OR 2. The requested agent is medically appropriate for the patient's age and sex OR B. The patient's sex is female and ONE of the following: <ol style="list-style-type: none"> 1. The patient is postmenopausal OR 2. The requested agent is medically appropriate for the patient's sex and menopause status AND 2. The patient's diagnosis was confirmed by ONE of the following: <ol style="list-style-type: none"> A. A fragility fracture in the hip or spine OR B. A T-score of -2.5 or lower OR C. A T-score of -1.0 to -2.5 and ONE of the following: <ol style="list-style-type: none"> 1. A fragility fracture of the proximal humerus, pelvis, or distal forearm OR 2. A FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20% OR 3. A FRAX 10-year probability of hip fracture of greater than or equal to 3% AND 3. The patient has ONE of the following: <ol style="list-style-type: none"> A. A very high fracture risk as defined by ONE of the following: <ol style="list-style-type: none"> 1. Has had a recent fracture (within the past 12 months) OR 2. Has had fractures while on FDA labeled osteoporosis therapy OR 3. Has had multiple fractures OR 4. Has had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids) OR 5. Has a very low T-score (less than -3.0) OR 6. Is at high risk for falls or has a history of injurious falls OR 7. Has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm OR B. ONE of the following: <ol style="list-style-type: none"> 1. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The prescriber has stated that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer OR 2. The prescriber has submitted documentation that the patient has been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer [chart notes are required] AND B. The use of the requested agent is consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-

Module	Clinical Criteria for Approval
	<p style="text-align: center;">based literature; and approved by the United States Food and Drug Administration OR</p> <ol style="list-style-type: none"> 2. Tried and had an inadequate response to a bisphosphonate (medical records required) OR 3. Has an intolerance or hypersensitivity to a bisphosphonate (medical records required) OR 4. Has an FDA labeled contraindication to ALL bisphosphonates (medical records required) AND <ol style="list-style-type: none"> 2. The patient will NOT be using the requested agent in combination with a bisphosphonate, denosumab (e.g., Prolia, Xgeva), romosozumab-aqqg, or another parathyroid hormone analog for osteoporosis (e.g., teriparatide) AND 3. The patient does NOT have any FDA labeled contraindications to the requested agent AND 4. The total duration of treatment with Forteo (teriparatide), Bonsity, Teriparatide, and Tymlos (abaloparatide) has NOT exceeded 2 years in a lifetime <p>Length of Approval:</p> <p>BCBSOK: 36 months BCBSIL and BCBSMT: 12 months ALL other plans: up to the remainder of a total of 2 years of treatment in a lifetime between FORTEO (teriparatide), Bonsity, Teriparatide, and Tymlos (abaloparatide). [Approve at least 3 months for BCBSNM/BCBSMT]</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS NM Fully Insured or NM HIM member and ALL of the following: <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. The requested indication is a rare disease AND C. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 2. ALL of the following: <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double

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	<p style="text-align: center;">blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</p> <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months: ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit <p>Length of Approval:</p> <p>BCBSIL: 12 months, up to 2 years</p> <p>All other plans: up to 2 years</p>