GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
BONE RESORPTION SUPPRESSION AND RELATED AGENTS PA SUMMARY

Preferred	Non-Preferred
Alendronate tablets generic Calcitonin-salmon nasal spray generic	Alendronate solution generic Atelvia (risedronate delayed release) Binosto (alendronate effervescent tablets) Forteo (teriparatide) Fosamax Plus D (alendronate/cholecalciferol) Ibandronate tablets, injection generic Miacalcin injection (calcitonin-salmon) Risedronate generic Risedronate delayed-release (DR) generic Tymlos (abaloparatide) Yorvipath (palopegteriparatide)

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- If the medication is being administration in a physician's office or clinic, please go to the Registered User portion of the Georgia Health Partnership website at www.mmis.georgia.gov/portal to request coverage from Physician Services.
- If generic risedronate DR is approved, the PA will be issued for brand Atelvia.

PA CRITERIA:

Atelvia, Ibandronate Tablets Generic, Risedronate Generic, Risedronate DR Generic

- ❖ Approvable for members that have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with the preferred product, generic alendronate tablet.

Alendronate Oral Solution Generic and Binosto

- ❖ Approvable for members unable to swallow solid oral dosage forms of medication that prevents the use of the preferred product, generic alendronate tablet.

Ibandronate Injection Generic

- ❖ Approvable when administered in the member's home or in a long-term care facility

AND

- ❖ Member is unable to swallow or absorb solid oral dosage forms of medication that prevents the use of the preferred product, generic alendronate tablet.

OR

- ❖ Member has experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with the preferred product, generic alendronate tablet.

Forteo

- ❖ Approvable for the treatment of osteoporosis in members 18 years of age or older at high risk for fracture who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with oral bisphosphonates or the member is unable to swallow or absorb solid oral dosage forms of medication.
- ❖ Approvable for the treatment of glucocorticoid-induced osteoporosis in members 18 years of age or older who are on sustained systemic glucocorticoid therapy, at high risk for fracture and have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with oral bisphosphonates or the member is unable to swallow or absorb solid oral dosage forms of medication.
- ❖ Approvable for the treatment of severe ongoing bone loss in members 18 years of age or older who are at high risk for fracture.
- ❖ Approvable for the treatment of hypoparathyroidism in members 18 years of age or older whose corrected serum calcium concentration is not able to be maintained with calcium and calcitriol (active vitamin D) supplementation.
- ❖ Must be prescribed by or in consultation with an endocrinologist.

Fosamax Plus D

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic alendronate tablet, is not appropriate for the member.

Miacalcin Injection

- ❖ Approvable when administered in the member's home or in a long-term care facility

AND

- ❖ Member requires rapid decrease in calcium

OR

- ❖ Member has nasal trauma, nasal ulcers or other circumstance that prevents the use of the preferred product, generic calcitonin-salmon nasal spray.

Tymlos

- ❖ Approvable for the treatment of osteoporosis in postmenopausal members 18 years of age or older at high risk for fracture who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with oral bisphosphonates or the member is unable to swallow or absorb solid oral dosage forms of medication.
- ❖ Must be prescribed by or in consultation with an endocrinologist.

Yorvipath

- ❖ Approvable for the treatment of hypoparathyroidism in members 18 years of age or older whose parathyroid (PTH) level is less than 20 pg/mL, albumin-corrected serum calcium level is 7.8 mg/dL or greater, serum 25-hydroxy [25(OH)] vitamin D level is 20 ng/mL or greater and corrected serum calcium concentration is not able to be maintained with calcium and calcitriol (active vitamin D) supplementation.
- ❖ Must be prescribed by or in consultation with an endocrinologist.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

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PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.