MEDICATION POLICY:
Forteo®

Generic Name: Teriparatide

Therapeutic Class or Brand Name: Forteo®

Applicable Drugs (if Therapeutic Class): N/A

Preferred: Teriparatide

Non-preferred: Forteo®

Date of Origin: 2/1/2013

Date Last Reviewed / Revised: 8/15/2023

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through IV are met)

I. Documented diagnosis of one of the following conditions A through C:
   a. Postmenopausal female patients with osteoporosis.
   b. Male patients with primary or hypogonadal osteoporosis.
   c. Female and male patients with osteoporosis likely caused by systemic glucocorticoid therapy.

II. Patient must be at high risk for fracture defined by meeting either criterion 1or 2:
   1. Have a bone mineral density that is 2.5 or more standard deviations below that of a "young normal" adult (T-score at or below –2.5).
   2. Have osteopenia (T-score between -1 and -2.5) and a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5 mg per day of prednisone (or equivalent).

III. Documented trial and failure of (following a 24-month treatment period), intolerance to, or contraindication to at least one bisphosphonate (i.e., alendronate, etidronate, ibandronate, risedronate, zoledronic acid, etc.).

IV. Refer to plan document for the list of preferred products. If requested agent is not listed as a preferred product, must have a documented failure, intolerance, or contraindication to the preferred product(s).

EXCLUSION CRITERIA

- Patients with Paget's disease of bone.
- Pediatric or young adult patients with open epiphyses.
- Patients with prior external beam or implant radiation therapy involving the skeleton.
- Patients with bone metastases, history of skeletal malignancies, metabolic bone diseases other than osteoporosis, or hypercalcemic disorders.
- Use of Forteo® for more than 2 years during a patients' lifetime.

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- One 2.4mL prefilled injectable pen per 28 days.

APPROVAL LENGTH

- **Authorization:** 24 months with no renewal option.
- **Re-Authorization:** N/A.

APPENDIX

N/A

REFERENCES

1. Forteo. Prescribing information. Lilly USA LLC; 2021. Accessed August 15, 2022. https://pi.lilly.com/us/forteo-pi.pdf.
2. Qaseem A, Forciea MA, McLean RM, et al. Treatment of low bone density or osteoporosis to prevent fractures in men and women: A Clinical Practice Guideline Update From the American College of Physicians. Ann Intern Med. 2017 Sep 19;167(6):448]. Ann Intern Med. 2017;166(11):818-839. Accessed September 15, 2022. https://doi.org/10.7326/M15-1361.