



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1163-9
Program	Prior Authorization/Notification
Medication	Natpara [®] (parathyroid hormone analog)
P&T Approval Date	10/2015, 9/2016, 9/2017, 9/2018, 9/2019, 9/2020, 9/2021, 9/2022, 9/2023
Effective Date	12/1/2023

1. Background:

Natpara is a parathyroid hormone indicated as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism.

Limitations of Use:

- Because of the potential risk of osteosarcoma, Natpara is recommended only for patients who cannot be well-controlled on calcium supplements and active forms of vitamin D alone. It is available only through a restricted program called the Natpara REMS Program.
- Natpara was not studied in patients with hypoparathyroidism caused by calcium-sensing receptor mutations.
- Natpara was not studied in patients with acute post-surgical hypoparathyroidism.

2. Coverage Criteria^a:

A. Hypoparathyroidism

1. Initial Therapy

a. **Natpara** will be approved based on **all** of the following criteria:

(1) Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism

-AND-

(2) Patient is on active vitamin D (calcitriol) therapy prior to starting Natpara

-AND-

(3) **One** of the following

a. Patient is currently on calcium supplementation

-OR-

b. Patient has a contraindication to calcium supplementation

Authorization will be issued for 6 months.

2. **Reauthorization**

a. **Natpara** will be approved based on the following criterion:

- (1) Documentation of positive clinical response to Natpara therapy

Authorization will be issued for 12 months

^a State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. **Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Medical Necessity may be in place

4. **References:**

1. Natpara[®] [package insert]. Lexington, MA: Takeda Pharmaceuticals U.S.A., Inc.; February 2023.

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Change Control	
10/2015	New program.
9/2016	Annual Review. No changes.
9/2017	Annual review with no changes to coverage criteria. Updated reference.
9/2018	Annual review with no changes to coverage criteria.
9/2019	Annual review with no changes to coverage criteria. Updated reference.
9/2020	Annual review with no changes to coverage criteria. Updated reference.
9/2021	Annual review with no changes to coverage criteria. Updated references.
9/2022	Annual review with no changes to coverage criteria. Added state mandate footnote.
9/2023	Annual review with no changes to coverage criteria. Updated reference.