Pharmacy Medical Necessity Guidelines: Hyperkalemia Agents

Effective: May 12, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM:
617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Veltassa (patiromer) is a potassium binder indicated for the treatment of hyperkalemia. It should not be used as an emergency treatment for life-threatening hyperkalemia due to its delayed onset of action.

Lokelma (sodium zirconium cyclosilicilate) is a potassium binder indicated for the treatment of hyperkalemia in adults. It should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

COVERAGE GUIDELINES

The plan may authorize coverage of Veltassa (patiromer) or Lokelma (sodium zirconium cyclosilicilate) for Members when **all** of the following criteria are met:

1. Member had a diagnosis of hyperkalemia

AND

2. Member had an inadequate response, intolerance, or contraindication to sodium polystyrene sulfonate

LIMITATIONS

None

CODES

None

REFERENCES

1. Veltassa (patiromer) [prescribing information]. Redwood City, CA: Relypsa, Inc; May 2018.
2. Lokelma (sodium zirconium cyclosilicilate) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals; April 2020.

APPROVAL HISTORY

May 9, 2017: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. July 10, 2018: No changes.
2. June 11, 2019: Added criteria for Lokelma to the MNG. Changed the title of the MNG from "Veltassa" to "Hyperkalemia Agents." Administrative changes made to template.
3. May 12, 2020: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in

coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink^{SM} Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.