

Effective Date 09/01/2018
Reviewed: 7/2018, 7/2019, 8/2020, 12/2020, 4/2021, 3/2022, 4/2023, 4/2024, 1/2025, 02/2026
Scope: Medicaid

VELTASSA (patiromer)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

- A. Member is 12 years old or older; AND
- B. Member has a diagnosis of hyperkalemia (serum potassium greater than 5 mEq/L); AND
- C. Medication is prescribed by, or in consultation with a nephrologist OR cardiologist; AND
- D. Member does not have a diagnosis of a gastrointestinal motility disorder; AND
- E. Member has inability to control hyperkalemia with other interventions such as:
 - a. Discontinuation of NSAIDs, OR
 - b. Dose reduction or discontinuation of offending agents if serum potassium is greater than 6.5 mEq/L (i.e., ACE inhibitors, ARBs or aldosterone antagonists); AND
- F. Member has experienced a failure, contraindication or intolerance to a loop diuretic, short term therapy with sodium polystyrene sulfonate AND if the member is 18 years of age and older they have experienced a failure, contraindication, or intolerance to Lokelma
- G. Member will not use Veltassa concomitantly with Lokelma

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who are tolerating treatment and have documentation of a positive clinical response with no severe side effects (i.e., hypokalemia) and do not have a diagnosis of a gastrointestinal motility disorder.

III. QUANTITY LIMIT

Veltassa 1gm: 4 packets per day

Veltassa 8.4gm, 16.8gm, 25.2 gm: 1 packet per day

IV. COVERAGE DURATION

- 12 months

V. REFERENCES

1. Veltassa [package insert]. Redwood City, CA: Relypsa, Inc.; January 2025. Accessed January 2026.