

Effective Date 09/01/2018
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Scope: Medicaid

## Veltassa (patiomer)

### POLICY

#### I. CRITERIA FOR APPROVAL

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

- A. Patient is 18 years old or older; AND
- B. Patient 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. Patient does not have a diagnosis of a gastrointestinal motility disorder, end stage renal disease AND is not currently receiving hemodialysis; AND
- E. Patient 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. Patient has experienced a failure, contraindication or intolerance to a loop diuretic, sodium polystyrene sulfonate AND 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, end stage renal disease AND is not currently receiving hemodialysis.

#### III. QUANTITY LIMIT

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.; December 2021.