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| Effective Date 09/01/2018   |
| Reviewed: 7/2018, 7/2019, 8/2020, 12/2020, 4/2021, 3/2022, 4/2023 |
| 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; 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, short term therapy with sodium polystyrene sulfonate AND Lokelma
- G. Patient 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 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.; March 2023.