Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Veltassa (patiromer)***
DEPARTMENT: **Clinical Pharmacy Services- Utilization Management**
ORIGINAL DATE: ***January 2016***

Last P & T Committee Approval Date: *February 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Veltassa (patiromer).

Veltassa (patiromer) is indicated for the treatment of non-emergent hyperkalemia.

DEFINITIONS

Hyperkalemia- elevation of serum potassium above normal ranges

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

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The drug, Veltassa (patiromer), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must have a diagnosis of hyperkalemia
- Must provide chart documentation of elevated potassium
- Must provide target potassium level
- Must have tried and failed the following:
    - Modification of current medication regimen to reduce the risk of hyperkalemia unless clinically inappropriate
    - Trial and failure of, contraindication to, or intolerance of sodium polystyrene sulfonate.

Reauthorization Criteria:

All prior authorization renewals are reviewed on a 1 month basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1 month intervals based upon chart documentation from the prescriber that the member's condition has improved based upon the following:

- Chart documentation of persistent hyperkalemia despite medication regimen modification
- Chart documentation of prior reduction in serum potassium levels with Veltassa

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 month
Reauthorization	Same as initial
Quantity Level Limit	
Veltassa	30 packets per 30 days

If the established criteria are not met, the request is referred to a Medical Director for review.

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REFERENCES

1. Veltassa™ oral solution [prescribing information]. Redwood City, CA: Relypsa Inc.; October 2015.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Annual review	*02/17, 02/18*

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