| Effective Date 09/01/2018 |
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| Reviewed: 7/2018, 7/2019, 8/2020, 12/2020, 4/2021, 3/2022, 4/2023, 4/2024<br>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. Patient is 12 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 if the patient is 18 years of age and older they have experienced a failure, contraindication, or intolerance to 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.; November 2023.