Updated: 09/2023
DMMA Approved: 09/2023

Request for Prior Authorization for Hyperkalemia Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Hyperkalemia Agents require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Hyperkalemia Agents Prior Authorization Criteria:

- The member is age appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer –reviewed medical literature
- Treatment is prescribed by, or in consultation with, a cardiologist or nephrologist
- There is documentation of recent laboratory values consistent with a diagnosis of hyperkalemia as evidenced by serum potassium levels at or above the upper limit of the normal reference range of the specific laboratory facility
- Will not be used as emergency treatment for life-threatening hyperkalemia
- Member must follow a low potassium diet (less than or equal to 3 grams per day)
- Provider has tried all of the following drug therapy modifications, as applicable, in an effort to address modifiable factors that may contribute to or cause hyperkalemia:
    - Member is taking no more than one medication from the following classes at one time:
        - Angiotensin converting enzyme (ACE) inhibitor
        - Angiotensin II receptor blocker (ARB)
    - Dose-reduction or discontinuation of medication(s) known to cause hyperkalemia
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to a loop or thiazide diuretic
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to sodium polystyrene sulfonate
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Must provide documentation that member's potassium level have normalized or decreased from baseline
    - Provider agrees to adjust the dosing based on the serum potassium level and desired target range

Reauthorization Duration of Approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or

peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK HEALTH OPTIONS

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HYPERKALEMIA AGENTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Product: ☐ Veltassa 8.4 gm powder packet ☐ Veltassa 25.2 gm powder packet
☐ Veltassa 16.8 gm powder packet

Product: ☐ Lokelma 5gm powder packet ☐ Lokelma 10gm powder packet

Directions:	Quantity:	Refills:
Is the patient currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

MEDICAL HISTORY

What is the patient's diagnosis? ☐ Hyperkalemia ☐ Other (please specify):

Please provide the most recent serum potassium levels and include the normal reference range.

Potassium (with reference range): **Date taken:**

Has the provider tried *all of the following* drug therapy modifications, as applicable, in an effort to address modifiable factors that may contribute to or cause hyperkalemia?

- Discontinuation of potassium supplements ☐Yes ☐No ☐N/A
- ARB/ACE inhibitor have been discontinued ☐Yes ☐No ☐N/A
  - If ARB/ACE inhibitors are still being used, is therapy limited to one agent? ☐Yes ☐No
- NSAIDs have been discontinued ☐Yes ☐No ☐N/A
- Dose-reduction or discontinuation of medications known to cause hyperkalemia ☐Yes ☐No ☐N/A

Has the member tried using a loop or thiazide diuretic? ☐Yes ☐No

If no, please provide rationale: _____

_____

_____

_____

Will the member follow a low potassium diet (less than or equal to 3 grams per day)? ☐Yes ☐No

Has the patient had an inadequate response or intolerance to sodium polystyrene sulfonate? ☐Yes ☐No ☐Yes ☐No

If **yes**, please complete ***previous therapy*** section below. If **no**, please provide rationale: _____

_____

PREVIOUS THERAPY

Drug Name	Strength/Frequency	Dates of Therapy	Status (Discontinued & Why or Current)

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HYPERKALEMIA AGENTS (continued)
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MEMBER INFORMATION

Member Name:	
Member ID:	DOB:

REAUTHORIZATION

Please provide a serum potassium level since the previous authorization.
Level (with reference range): **Date of level:**

Provider agrees to adjust the dose of the drug based on the serum potassium level and desired target range:
☐ Yes ☐ No

Prescribing Physician Signature	Date