Updated: 12/2018
PARP Approved: 12/2018

Prior Authorization Criteria

Hyperkalemia agents

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

Coverage may be provided with a diagnosis of hyperkalemia and the following criteria is met:

- The member is 18 years of age or older
- 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
- Veltassa or Lokelma will not be used as emergency treatment for life-threatening hyperkalemia
- 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:
    - Discontinuation of potassium supplements
    - Discontinuation of NSAIDs
    - 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-adjustment or discontinuation of renin-angiotensin-aldosterone system (RAAS) inhibitors
- 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
- 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 demonstrates member is receiving clinical benefit from treatment (e.g. potassium level returned to normal or significant decrease 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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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 Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____________pounds or ____________kg

REQUESTED DRUG INFORMATION

Product: ☐ Veltassa 8.4 gm powder packet ☐ Veltassa 25.2 gm powder packet
☐ Veltassa 16.8 gm powder packet
☐ Lokelma 5gm powder packet ☐ Lokelma 10gm powder packet

Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:___________________________

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Hyperkalemia ☐ Other: _______________________________ ICD-10 Code: ______________

Please provide the most recent serum potassium levels and include the normal reference range.
K (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-adjustment of renin-angiotensin-aldosterone system (RAAS) inhibitors ☐Yes ☐No ☐N/A

Has the member tried using a loop or thiazide diuretic? ☐Yes ☐No
If no, please provide rationale:

CURRENT or PREVIOUS THERAPY

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

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 potassium level and desired target range: ☐ Yes ☐ No

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SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date