Gateway Health It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Potassium Removing Agents

A. Prescriptions That Require Prior Authorization

All prescriptions for Potassium Removing Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Potassium Removing Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed the Potassium Removing Agent by or in consultation with a cardiologist or nephrologist; **AND**

5. Has documentation of recent serum potassium levels consistent with a diagnosis of hyperkalemia; **AND**

6. Has documented therapeutic failure of **all** of the following:

   a. A low potassium diet,
   b. A loop or thiazide diuretic, if clinically appropriate,
   c. Discontinuation or dose reduction to the minimum effective dose of medications known to cause hyperkalemia;

   AND

7. For a non-preferred Potassium Removing Agent, has a history of therapeutic failure, contraindication, or intolerance of the preferred Potassium Removing Agents. See the Preferred Drug List (PDL) for the list of preferred Potassium Removing Agents at: https://papdl.com/preferred-drug-list

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRESCRIPTIONS FOR POTASSIUM REMOVING AGENTS: The determination of medical necessity of requests for prior authorization of renewals of prescriptions for Potassium Removing Agents that were previously approved will take into

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account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Is prescribed the Potassium Removing Agent by or in consultation with a cardiologist or nephrologist; **AND**

3. Has documentation of recent serum potassium levels demonstrating a positive clinical response to therapy

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of the request for a prescription for a Potassium Removing Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Potassium Removing Agents will be approved as follows:

1. Initial requests for prior authorization of Potassium Removing Agents will be approved for up to 3 months.

2. Renewals of requests for prior authorization of Potassium Removing Agents will be approved for up to 12 months.

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POTASSIUM REMOVING AGENTS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength/formulation:	
Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Diagnosis code (*required*):	

Is the medication being prescribed by or in consultation with a cardiologist or nephrologist?	☐Yes	☐No	*Submit documentation.*
INITIAL requests			
Does the beneficiary have a recent serum potassium level(s) consistent with hyperkalemia? Serum potassium: _____ Date obtained: _____ Serum potassium: _____ Date obtained: _____	☐Yes	☐No	*Submit documentation.*
Has the beneficiary tried and failed a low potassium diet?	☐Yes	☐No	*Submit documentation.*
Has the beneficiary tried and failed a loop or thiazide diuretic (if clinically appropriate)? Diuretic(s) tried: _____ Reason diuretics cannot be tried: _____	☐Yes	☐No	*Submit documentation.*
Submit the beneficiary's complete medication list. If the beneficiary is taking any medications that are known to cause hyperkalemia, has the beneficiary tried and failed discontinuation or dose reduction of these medications?	☐Yes	☐No	*Submit documentation.*
For a non-preferred medication: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents in this class that are approved or medically accepted for the beneficiary's diagnosis? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes	☐No	*Submit documentation.*
RENEWAL requests			
Has the beneficiary experienced a positive clinical response since starting the requested medication? Serum potassium: _____ Date obtained: _____ Serum potassium: _____ Date obtained: _____	☐Yes	☐No	*Submit documentation.*

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: