Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.730	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Potassium Removing Agents	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2022 annual review: no changes.

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Potassium Removing Agents

Reference Number: PHW.PDL.730
Effective Date: 01/01/2020
Last Review Date: 10/2021

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Potassium Removing Agents are **medically necessary** when the following criteria are met:

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; **AND**

8. If a prescription for a Potassium Removing Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   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 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; **AND**

4. If a prescription for a Potassium Removing Agent is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   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 3 months.

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

E. References

1. Lokelma [package insert]. Wilmington, DE: AstraZeneca Pharmaceuticals; May 2018.
2. Mount, DB. Treatment and Prevention of Hyperkalemia in Adults. Sterns RH, Forman, JP eds. Waltham, MA: UpToDate Inc. Updated December 18, 2017. Accessed April 30, 2019.
3. Veltassa [package insert]. Redwood City, CA: Relypsa, Inc.; May 2018.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	10/2021