Clinical Policy: Patiromer (Veltassa)

Reference Number: CP.PMN.205
Effective Date: 09.01.19
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Patiromer (Veltassa®) is a non-absorbed potassium-binding polymer.

FDA Approved Indication(s)

Veltassa is indicated for the treatment of hyperkalemia in adults and pediatric patients 12 years of age and older.

Limitation(s) of use: Veltassa should not be used as an emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

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 Centene Corporation® that Veltassa is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hyperkalemia (must meet all)**:**

1. Diagnosis of hyperkalemia;
2. Age ≥ 12 years;
3. If age ≥ 18 years, failure of Lokelma®*†, unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization may be required for Lokelma*
   †For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395
4. Dose does not exceed 25.2 g per day.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of

business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Hyperkalemia (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 25.2 g per day.

Approval duration:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents;

B. Emergency treatment for life-threatening hyperkalemia because of its delayed onset of action.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Lokelma (sodium zirconium cyclosilicate)	Initial: 10 g PO TID for up to 48 hrs Maintenance: 10 g PO QD (adjust dose by 5 g as needed at weekly intervals)	15 g/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to Veltassa or any of its components
- Boxed warning(s): none reported

Appendix D: General Information

- Veltassa binds to many orally administered medications, which could decrease their absorption and reduce their effectiveness. Administer Veltassa at least 3 hours before or 3 hours after other oral medications except those shown to not have a clinically important interaction.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hyperkalemia	Adult dosing: Initial dose is 8.4 g PO daily Adjust dose by 8.4 g as needed at weekly intervals Pediatric dosing 12 years of age and older: Initial dose is 4 g PO daily Adjust dose by 4 g as needed at weekly intervals	25.2 g/day

VI. Product Availability

Packets, powder for oral suspension: 1 g, 8.4 g, 16.8 g, and 25.2 g

VII. References

1. Veltassa Prescribing Information. Redwood City, CA: Vifor Pharma, Inc; January 2025. Available at: https://veltassa.com/hcp/pi. Accessed April 12, 2026.

2. Bakris GL, Pitt B, Weir MR, et al. Effect of patiromer on serum potassium levels in patients with hyperkalemia and diabetic kidney disease: The AMETHYST-DN randomized clinical trial. JAMA. 2015; 314(2):151-161.
3. Weir MR, Bakris GL, Bushinsky DA, et al; for the OPAL-HK Investigators. Patiromer in patients with kidney disease and hyperkalemia receiving RAAS inhibitors. N Engl J Med. 2015; 372(3):211-221.
4. Micromedex® Healthcare Series [Internet database]. Ann Arbor, Michigan: Merative™. Updated periodically. Accessed April 27, 2026.
5. Esposito P, Conti NE, Falqui V, et al. New Treatment Options for Hyperkalemia in Patients with Chronic Kidney Disease. J Clin Med. 2020;9(8):2337.
6. Renal Association: Clinical Practice Guidelines Treatment of Acute Hyperkalemia in Adults 2019 (Final version: June 2020). Available at: https://ukkidney.org/sites/renal.org/files/RENAL%20ASSOCIATION%20HYPERKALAEMIA%20GUIDELINE%20-%20JULY%202022%20V2_0.pdf. Accessed April 27, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
3Q 2023 annual review: per May SDC, added redirection to Lokelma; references reviewed and updated.	05.24.23	08.23
RT4: newly FDA approved indication reflected with pediatric age extension down to 12 years of age; added new formulation of 1 gm powder pack.	10.19.23	
3Q 2024 annual review: for section VI, removed "1 g" as strength is discontinued per FDA website and Medispan; references reviewed and updated.	05.09.24	08.24
3Q 2025 annual review: for section VI, added "1 g" strength as supported by clinical pharmacology and still active in Medispan; references reviewed and updated.	04.15.25	08.25
Added step therapy bypass for IL HIM per IL HB 5395.	05.05.26	
3Q 2026 annual review: no significant changes; for initial therapy, updated Medicaid and HIM approval duration from 6 months to 12 months for chronic therapy; references reviewed and updated. Added ICHRA line of business.	07.08.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical

practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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