



## Drug Quantity Management – Per RX Veltassa® (patiromer for oral suspension) Dispensing Limit

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### Product Identifier(s)

**Effective 1/1/23 to 3/21/23:** 108899  
**Effective 3/22/23:** 63481

#### INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

### National Formulary Medical Necessity

#### Veltassa 8.4 gram, 16.8 gram and 25.2 gram packets

Maximum quantity per RX = 30 packets

A quantity of thirty (30) 8.4 gram, 16.8 gram, or 25.2 gram packets will be covered per dispensing without coverage review. This is enough drug for a 30-day supply at daily dosing. The objective of this program is to manage dose titration and provide for dose consolidation. Additional quantities for dose titration can be made available through coverage review.

#### Criteria

**Cigna covers quantities as medically necessary when the following criteria are met:**

All approvals are provided for 1 year in duration unless otherwise noted below.

#### **Veltassa 8.4 gram packets**

1. For individuals requiring a dose titration to 16.8 grams – 25.2 grams daily, approve a one-time override for up to quantity of 90 packets.

## Veltassa 16.8 gram and 25.2 gram packets

1. No overrides recommended.

## Conditions Not Covered

Any other exception is considered not medically necessary.

## Background

### Overview

Veltassa is indicated for the treatment of hyperkalemia. Veltassa is available in 8.4 gram, 16.8 gram and 25.2 gram packets. The recommended starting dose of Veltassa is 8.4 grams administered orally once daily. The dose can be adjusted by 8.4 grams daily as needed at one-week intervals up to 25.2 grams daily to obtain the desired serum potassium range.

## References

1. Veltassa® [prescribing information]. Redwood City, CA: Relypsa, Inc.; May 2018.

## Revision History

| Type of Revision | Summary of Changes  | Approval Date |
|------------------|---|---------------|
| Annual Revision  | Reviewed by Clinical Specialists. No change to clinical criteria. | 08/30/2020    |

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