Louisiana Medicaid
Potassium Binders

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Prior authorization for non-preferred potassium binders (except Veltassa®)
- Clinical authorization for patiromer (Veltassa®)

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE. ~~These agents may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.~~

Approval Criteria for Non-Preferred Potassium Binder Agents (except Veltassa®)

Approval Criteria for Initiation and Continuation of Therapy

~~**Approval Criteria for Initial and Reauthorization Requests**~~

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - The recipient has had *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
  - The recipient is established on the medication with positive clinical outcomes.~~;~~ ~~**AND**~~

~~- By submitting the authorization request, the prescriber attests to the following:~~
  ~~- The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~

- ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**~~
- ~~The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.~~

Duration of approval for initiation and continuation of therapy~~Duration of initial and reauthorization approval~~: ~~12 months

---

Patiromer (Veltassa®)

Approval Criteria for Initiation of Therapy

- The recipient is at least 12~~8~~ years of age on the date of the request; **AND**
- The recipient has a diagnosis of non-life-threatening hyperkalemia; **AND**
- The dose does not exceed 25.2 grams once a day; **AND**
- ~~The quantity does not exceed 1 packet per day; **AND**~~
- If the request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.~~; **AND**~~
- ~~By submitting the authorization request, the prescriber attests to the following:~~
  - ~~The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~
  - ~~Patiromer will **NOT** be used as an emergency treatment for life threatening hyperkalemia because of its delayed onset of action; **AND**~~
  - ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**~~
  - ~~The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.~~

Approval Criteria for Continuation of Therapy

~~**Reauthorization Criteria**~~

- ~~The recipient continues to meet initial approval criteria; **AND**~~
- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy~~**Duration of initial and reauthorization approval**~~**: 12 months**

Reference

Veltassa (patiromer) [package insert]. Redwood City, CA: Relypsa, Inc; January~~March~~ 2025~~3~~. https://www.veltassa.com/hcp/pi~~https://www.veltassa.com/pi.pdf~~

Revision / Date	Implementation Date
Combined Lokelma® and Veltassa® criteria, added previous use wording, formatting changes, removed POS wording, updated references / April 2021	July 2021
Removed clinical authorization wording for Lokelma® / May 2023	July 2023
Modified age limit for Veltassa®, removed Veltassa® quantity limit criterion, formatting changes, updated references / March 2025	August 2025