HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

HYPERKALEMIA

Lokelma®, Veltassa®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Veltassa® (patiromer)
Non-Preferred: ☐ Lokelma® (sodium zirconium cyclosilicate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for Hyperkalemia?	☐	☐	
2. Is the member between the ages of 18-80?	☐	☐	
3. Is the request from, or in consultation with, a nephrologist or a cardiologist, or is the member pending hospital discharge?	☐	☐	
4. Does the member have a serum potassium level between 5.5-6.5 mmol/L on two separate screenings?	☐	☐	**Please Provide Documentation**
5. If applicable, has the member tried dietary consultations to limit potassium intake?	☐	☐	**Please Provide Documentation**
6. If applicable, has the member tried discontinuing non-steroidal anti-inflammatories?	☐	☐	**Please Provide Documentation**
7. If applicable, has the member tried discontinuing potassium supplements?	☐	☐	**Please Provide Documentation**
8. If applicable, has the member tried reducing or discontinuing angiotensin enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), or renin-angiotensin-aldosterone system (RAAS) inhibitors?	☐	☐	**Please Provide Documentation**
9. Has the member had a trial and failure of a loop or thiazide diuretic (excluding potassium-sparing diuretics)?	☐	☐	**Please Provide Documentation**

10. Is the requested medication being used to bridge a member with stage 5 kidney dysfunction to dialysis?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show that the member's serum potassium is <5.5 mmol/L secondary to the use of patiromer (Veltassa)?	☐	☐	**Please Provide Documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy PHARM-HU-033
Origination Date: 01/01/2022
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