Clinical Policy: Non-Calcium Phosphate Binders (Auryxia, Fosrenol, Renvela, Renagel, Velphoro)

Reference Number: AZ.CP.PMN.04
Effective Date: 11.15.17
Last Review Date: 01.20
Line of Business: Arizona Medicaid

Revision Log

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

Description
The following are non-calcium containing phosphate binders requiring prior authorization: ferric citrate (Auryxia®), lanthanum carbonate (Fosrenol®), sevelamer carbonate (Renvela®), sevelamer hydrochloride (Renagel®), sucroferric oxyhydroxide (Velphoro®).

AHCCCS preferred drugs in this class include: generic calcium acetate tablets, generic calcium acetate capsules.

AHCCCS non-preferred drugs in this class include: Auryxia, Fosrenol, Renvela, Renagel, sevelamer packets, Velphoro,

FDA approved indications

Non-calcium containing phosphate binders (Auryxia, Fosrenol, Renvela, Renagel, and Velphoro) are indicated for the control of serum phosphorus levels in patients with chronic kidney disease (CKD) on dialysis or with end stage renal disease (ESRD).

Auryxia is also indicated for the treatment of iron deficiency anemia in adult patients with CKD not on dialysis.

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 Arizona Complete Health that [Brand name(s)] [is/are] are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of hyperphosphatemia associated with CKD or ESRD;
2. Prescribed by or in consultation with a nephrologist, or member is on dialysis;
3. Member meets one of the following (a or b):
   a. Auryxia, Fosrenol, Renagel, Velphoro: age ≥ 18 years;
   b. Renvela: age ≥ 6 years;
4. Member meets one of the following (a, b, c, or d):

a. Failure (e.g., serum phosphorus > 5.5 mg/dL) of a 4-week trial of generic calcium acetate capsules or tablets at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
b. Hypercalcemia as evidenced by recent (within the previous 30 days) corrected total serum calcium level > 10.2 mg/dL;
c. Plasma parathyroid hormone (PTH) levels < 150 pg/mL on 2 consecutive measurements in the past 180 days;
d. History of severe vascular and/or soft-tissue calcifications;

5. For Auryxia, Fosrenol, Velphoro, or Renagel: failure (e.g., serum phosphorus > 5.5 mg/dL) of a 4-week trial of Renvela (generic is preferred) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. For sevelamer carbonate packets, difficulty swallowing;
7. Dose does not exceed:
   a. Auryxia: 12 tablets (2,520 mg ferric iron) per day;
   b. Fosrenol: 4,500 mg per day;
   c. Renagel: 13 g per day;
   d. Renvela: 14 g per day;
   e. Velphoro: 3,000 mg (6 tablets) per day.

Approval duration:
Medicaid – 12 months

B. Iron Deficiency Anemia (must meet all):
1. Request is for Auryxia;
2. Diagnosis of iron deficiency anemia with CKD not on dialysis;
3. Failure of a 4-week, adherent trial of alternative oral iron therapy (e.g., ferrous sulfate, ferrous fumarate, ferrous gluconate), unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 12 tablets (2,520 mg ferric iron) per day.

Approval duration:
Medicaid – 12 months

C. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy (e.g., reduction in serum phosphorus from pretreatment level; maintenance of serum phosphorus level < 5.5 mg/dL, increased hemoglobin);
3. If request is for a dose increase, new does not exceed one of the following (a, b, or c):
   a. Auryxia: 12 tablets (2,520 mg ferric iron) per day;

b. Fosrenol: 4,500 mg per day;
c. Renagel: 13 g per day;
d. Renvela: 14 g per day;
e. Velphoro: 3,000 mg (6 tablets) per day.

Approval duration:
Medicaid – 12 months

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): AZ.CP.PMN.53 for Arizona 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 – AZ.CP.PMN.53 for Arizona Medicaid.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CKD: chronic kidney disease
ESRD: end-stage renal disease
FDA: Food and Drug Administration
PTH: parathyroid hormone

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
calcium acetate	**Hyperphosphatemia** 2 capsules PO TID with meals; titrate to phosphorus < 6 mg/dL and calcium < 9.5 mg/dL	1,500 mg/day total elemental calcium
lanthanum (Fosrenol®)	**Hyperphosphatemia** 1,500 mg PO daily in divided doses; titrate by 750 mg/day every 2 to 3 weeks based on serum phosphorus level	4,500 mg/day
sevelamer carbonate (Renvela®)	**Hyperphosphatemia** *Starting dose for adult dialysis patients based on serum phosphorus level* If serum phosphorus is: > 5.5 to < 7.5 mg/dL: 0.8 g PO TID w/ meals	14 g/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	≥ 7.5 mg/dL: 1.6 g PO TID w/ meals *Starting dose for pediatric patients (6 years and older) based on body surface area (BSA)* ≥ 0.75 to < 1.2: 0.8 mg PO TID w/ meals ≥ 1.2: 1.6 g PO TID w/ meals *Starting dose for patients switching from calcium acetate to Renvela based on calcium acetate 667 mg/capsule dosing schedule* • Calcium acetate 1 cap PO TID: Renvela 0.8 g PO TID w/ meals • Calcium acetate 2 caps PO TID: Renvela 1.6 g PO TID w/ meals • Calcium acetate 3 caps PO TID: Renvela 2.4 g PO TID w/ meals	
ferrous sulfate, ferrous fumarate, ferrous gluconate	**Iron Deficiency Anemia** 100 to 200 mg elemental iron PO daily in 2 to 3 divided doses (or daily with extended release tablets)	Varies

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):
  - Auryxia: iron overload syndromes (e.g., hemochromatosis)
  - Fosrenol: bowel obstruction, ileus, and fecal impaction
  - Renagel: bowel onstruction; known hypersensitivity to sevelamer hydrochloride or to any of the excipients
  - Renvela: bowel obstruction
  - Velphoro: none reported
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
ferric citrate (Auryxia)	Iron Deficiency Anemia	1 tablet PO TID with meals. Adjust dose as needed to achieve and maintain hemoglobin goal.	12 tablets/day
ferric citrate (Auryxia)	Hyper-phosphatemia	2 tablets PO TID with meals; titrate by 1 to 2 tabs/day at	12 tablets/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		1-week or longer intervals based on serum phosphorus level	
lanthanum (Fosrenol)	Hyper-phosphatemia	1,500 mg PO daily in divided doses; titrate by 750 mg/day every 2 to 3 weeks based on serum phosphorus level	4,500 mg/day
sevelamer carbonate (Renvela)	Hyper-phosphatemia	*Starting dose for adult dialysis patients based on serum phosphorus level* If serum phosphorus is: > 5.5 to < 7.5 mg/dL: 0.8 g PO TID w/ meals ≥ 7.5 mg/dL: 1.6 g PO TID w/ meals *Starting dose for pediatric patients (6 years and older) based on body surface area (BSA)* ≥ 0.75 to < 1.2: 0.8 mg PO TID w/ meals ≥ 1.2: 1.6 g PO TID w/ meals *Starting dose for patients switching from calcium acetate to Renvela based on calcium acetate 667 mg/capsule dosing schedule* • Calcium acetate 1 cap PO TID: Renvela 0.8 g	14 g/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		PO TID w/ meals • Calcium acetate 2 caps PO TID: Renvela 1.6 g PO TID w/ meals Calcium acetate 3 caps PO TID: Renvela 2.4 g PO TID w/ meals	
sevelamer hydrochloride (Renagel)	Hyper-phosphatemia	*Starting dose based on serum phosphorus level* • 5.5 to < 7.5 mg/dL: Renagel 800 mg - 1 tab PO TID; 400 mg - 2 tabs PO TID w/meals • 7.5 to < 9 mg/dL: Renagel 800 mg - 2 tabs PO TID; 400 mg - 3 tabs PO TID w/meals • ≥ 9 mg/dL: Renagel 800 mg - 2 tabs PO TID; 400 mg - 4 tabs PO TID w/meals *Starting dose for patients switching from calcium acetate to Renagel based on calcium acetate 667 mg/capsule dosing schedule* • Calcium acetate 1 cap PO TID: Renagel 800 mg - 1 tab PO TID; 400 mg - 2 tabs PO TID	13 g/day

Drug Name	Indication	Dosing Regimen	Maximum Dose
		• Calcium acetate 2 caps PO TID: Renagel 800 mg - 2 tabs PO TID; 400 mg - 3 tabs PO TID Calcium acetate 3 caps PO TID: Renagel 800 mg - 3 tabs PO TID; 400 mg - 5 tabs PO TID	
sucroferric oxyhydroxide (Velphoro)	Hyper-phosphatemia	500 mg PO TID with meals	3,000 mg/day

VI. Product Availability

Drug Name	Availability
ferric citrate (Auryxia)	Tablets: 210 mg ferric iron (equivalent to 1 g ferric citrate)
lanthanum (Fosrenol)	Tablets, chewable: 500 mg, 750 mg, 1,000 mg Oral powder: 750 mg, 1,000 mg
sevelamer carbonate (Renvela)	Tablets: 800 mg Oral powder, packet: 0.8 g, 2.4 g
sevelamer hydrochloride (Renagel)	Tablets: 400 mg, 800 mg
sucroferric oxyhydroxide (Velphoro)	Tablets, chewable: 500 mg iron

VII. References

1. Auryxia Prescribing Information. Boston, MA: Keryx Biopharmaceuticals, Inc.; November 2017. Available at: https://www.auryxia.com/. Accessed October 30, 2018.
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6. National Kidney Foundation. K/DOQI Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease. Am J Kidney Dis 42:S1-S202, 2003 (suppl 3).

7. Kidney Disease: Improving Global Outcomes (KDIGO) CKD–MBD Work Group. KDIGO clinical practice guideline for the diagnosis, evaluation, prevention, and treatment of chronic kidney disease–mineral and bone disorder (CKD–MBD). Kidney International 2009; 76 (Suppl 113): S1–S130.
8. Kidney Disease: Improving Global Outcomes (KDIGO) CKD–MBD Work Group. KDIGO clinical practice guideline for the diagnosis, evaluation, prevention, and treatment of chronic kidney disease–mineral and bone disorder (CKD–MBD). Kidney International 2017; 92(1):26-36.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: Combined Medicaid and commercial non-calcium phosphate binder policies; Added trial duration of 4 weeks per guideline recommendations for monitoring frequency; Added additional requirement for trial of generic Fosrenol or generic Renvela; References reviewed and updated	11.16.17	02.18
Criteria added for new indication for Auryxia: for the treatment of iron deficiency anemia in adult patients with CKD not on dialysis.	01.16.18	05.18
1Q 2019 annual review: age requirement added for all agents; no significant changes; references reviewed and updated.	10.30.18	02.19
Adapted criteria to reflect AZ State Medicaid preference of brand Renvela and brand Renagel. Removed Commercial criteria references.	03.17.19	04.19
Updated criteria to reflect preferred products: calcium acetate and generic Renvela; Renumbered; Updated logo; references updated.	01.20	01.20

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.