

Clinical Policy: Sucroferric Oxyhydroxide (Velphoro)

Reference Number: HIM.PA.SP30

Effective Date: 05/17

Last Review Date:

Line of Business: Health Insurance Marketplace

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Sucroferric oxyhydroxide (Velphoro[®]) is a phosphate binder.

FDA approved indication

Velphoro is indicated for the control of serum phosphorus levels in patients with chronic kidney disease (CKD) on dialysis.

Policy/Criteria

Provider *must* submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

I. Initial Approval Criteria

A. Hyperphosphatemia (must meet all):

1. Diagnosis of hyperphosphatemia associated with CKD or end stage renal disease (ESRD);
2. Member is on dialysis;
3. Current (within the last 30 days) serum phosphorus > 5.5 mg/dL;
4. Failure of 2 formulary phosphate binders at therapeutic doses unless all are contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 3000 mg per day (6 tablets per day).

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Hyperphosphatemia (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy as evidenced by reduction in serum phosphorus from pretreatment level;
3. If request is for a dose increase, new dose does not exceed 3000 per day (6 tablets per day).

Approval duration: 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; or

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2. Refer to HIM.PHAR.21 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

Approval duration: 12 months

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 policy – HIM.PHAR.21 or evidence of coverage documents

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CKD: chronic kidney disease

ESRD: end-stage renal disease

FDA: Food and Drug Administration

V. References

1. Velphoro Prescribing Information. Waltham, MA: Fresenius Medical Care North America; September 2014. Available at: <http://velphoro.us/hcp>. Accessed January 30, 2017.
2. 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).
3. 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.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2016. Available at: <http://www.clinicalpharmacology-ip.com/>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01/17	

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

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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.

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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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