Chronic Kidney Disease: Health Leaders Network Medication Resource

(ST) step therapy (PA) prior auth

Humana	FMOLHS Plan	UHC	BCBS	Drug Class	Medication *(AWP cost / 30 days)*	**Clinical Points** **Adherence to < 2gm Na^+ and diabetic diets* **Sodium restriction enhances the effect of some anti-hypertensive meds*
2-vial	3-vial			**Thiazide & Thiazide - Like Diuretics**	Chlorothiazide	1. Thiazides are less effective as GFR declines but can be added to loop diuretics for enhanced diuresis 2. Chlorthalidone and Indapamide are long-acting 3. Increases risk of hypokalemia
1	1	1	$0		Chlorthalidone	
1	1	1	$0		Hydrochlorothiazide	
1	1	1	$0		Indapamide	
2	1	1	$0		Metolazone	
2	1	1	$0	**Loop Diuretics**	Bumetanide	1. Equivalency: Bumetanide 1mg = Torsemide 20mg = Furosemide 40mg 2. Torsemide, longer acting, may be preferred 3. Thiazides can be added to loop diuretics for enhanced diuresis
1-*tabs* 2-soln	1	1	$0		Furosemide	
2	1	1	$0		Torsemide	
	1	2	1	**Aldosterone Antagonists**	Eplerenone *(>$130)*	1. Preferred for primary aldosteronism and resistant hypertension 2. Risk of hyperkalemia 3.Finerenone is FDA approved reduced the risk of CV and renal outcomes in pts with T2DM & CKD (FIDELIO-DKD) 4. Finerenone use recommended when eGFR ≥25ml/min, albuminuria ≥30mg/g (≥3mg/mmol), and a normal serum potassium concentration
3 (PA)	3 (PA)	4(PA)			Finerenone (Kerendia *>$790*)	
1	1	1	$0		Spironolactone	
2	1	1	$0		Spironolactone / HCTZ	
1	1	1	$0	**ACE inhibitors** *ACE/ARB can reduce the risk of developing microalbuminuria or progression to macroalbuminuria*	Benazepril	1. Use for CKD with urine albumin >300mg/24hr, or CKD/DM pts with urine albumin >30-300mg/24hr 2. Monitor for hypotension, decreased GFR, and hyperkalemia 3. Not recommended for use in combination with ARB or Renin Inhibitors (increases CV and renal risks) 4. Consider use even if GFR <30ml/min due to reno-protective properties 5. Increases risks of hyperkalemia 6. Utilize K^+ binders to remain on ACE/ARB therapy
3	1	1	$0		Captopril	
1	1	1	$0		Enalapril	
1	1	1	$0		Fosinopril	
1	1	1	$0		Lisinopril	
1	1		1		Moexipril	
2	1	2	1		Perindopril	
1	1	1	$0		Quinapril	
1	1	1	$0		Ramipril	
1	1	1	1		Trandolapril	
3	1	3	1	**ARBs** *ACE/ARB can reduce the risk of developing microalbuminuria or progression to*	Candesartan	1. Use for CKD with urine albumin >300mg/24hr, or CKD/DM pts with urine albumin >30-300mg/24hr 2. Monitor for hypotension, decreased GFR, and hyperkalemia 3. Not recommended for use in combination with Ace Inhibitors or Renin Inhibitors (increases CV and renal risks)
					Azilsartan (Edarbi *>$310)*	
	1				Eprosartan	
1	1	1	$0		Irbesartan	

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1	1	1	$0	*macroalbuminuria*	Losartan	4. Consider use even if GFR <30ml/min due to reno-protective properties 5. Increases risks of hyperkalemia 6. Utilize K^+ binders to remain on ACE/ARB therapy 7. Patients with history of ACE angioedema may try ARB after six-week washout
1	1	2	$0		Olmesartan	
2	1	2	1		Telmisartan	
1	1	2	$0		Valsartan	
OTC	*OTC*	*OTC*	*OTC*	**Vitamin D preps** **nonactivated or activated*	**Cholecalciferol (D3)*	1. *Use when evidence of a documented deficiency, use general population guidelines for dosing 2. If CKD G4-5 and persistently elevated PTH, use calcitriol or vitamin D analogs for more direct effect on PTH
	3	1	1		**Ergocalciferol (D2)*	
2 - *cap* 4- *soln*	2	1	1		Calcitriol *(>$45)*	
4 3-*vials* 4-*caps*	3 (ST,PA) 1(ST,PA)	1	1 1		Doxercalciferol *(Hectorol generic >$350)* Paricalcitol *(Zemplar generic >$250)*	
	2			**Phosphate Binders**	Auryxia *(>$1,600)*	1. Auryxia may increase serum iron and the risk of aluminum toxicity 2. Elemental calcium should not exceed 1500mg/24hr 3. Renagel may contribute to metabolic acidosis 4. Velphoro has minimal increase in serum iron
	1	1-cap	1		Calcium acetate *(>$130)*	
OTC	OTC	OTC	*OTC*		Calcium carbonate *(>$10-$15)*	
	3		3 *(PA)*		Lanthanum carbonate *(>$1,200)*	
	1	2	3 *(PA)*		Sevelamer carbonate (>$300)	
	2				Sevelamer HCL *(Renagel generic >$650)*	
	3	4 (ST)	3 *(PA)*		Velphoro *(>$1,900)*	
3	1	3 (PA)	2	**Potassium Binders**	Lokelma *(>$900)*	1. Avoid in severe constipation, bowel obstruction, or impaction 2. Sodium from SPS & Lokelma may exacerbate edema 2. Veltassa may bind magnesium, consider supplementation 3. Separation of dosing may be warranted with other medications, typically 3hrs before or 3hrs after treatment 4. Should not be used as emergency treatments due to delayed onset of action
3	1	3	1		Sodium Polystyrene Sulfonate *(>$250)*	
	1	3 *(PA)*	3		Veltassa *(>$1,200)*	
				SGLT2 inhibitors	Brenzavvy *($50)*	1. SGLT2i class may have more marked effects on decreased hospitalizations for CHF and progression of CKD
3		(ST)			*Invokana *(>$700)*	

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3		(ST)		**May delay the progression of diabetic nephropathy; May reduce CV mortality in pts with established CV disease*	Invokamet *(>$700)*	2. May increase the risk of mycotic genital infections, including Fournier's gangrene 3. To reduce risk of AKI, consider diuretic dose reduction before starting 4. Risk of DKA, including euglycemic DKA 5. EMP-REG showed Jardiance may prevent new or worsening nephropathy in 1 out of 16 pts over 3 years. It is FDA approved for reducing CV mortality in DM pts with established CV disease 6. CREDENCE showed Invokana may prevent the doubling of SCr in 1 out of 31 DM pts over 2.62 years. 7. Farxiga when added to ACE or ARB therapy in CKD pts may reduce the decline in eGFR of at least 50% and delay the progression to ESRD (DAPA-CKD) 8. Standards of Diabetes Care 2023 states to use SGLT2i in people with an eGFR ≥20ml/min per 1.73m^2 to reduce CKD progression
3		(ST)			Invokamet XR *(>$700)*	
			2		Dapagliflozin (>$650) *Farxiga *(>$700)*	
			2		Dapagliflozin / Metformin ($>650) Xigduo XR *(>$675)*	
					Qtern *(>$675)*	
3	$0(PA)	2	2		*Jardiance *(>$730)*	
3	$0(PA)	2	2		Synjardy *(>$730)*	
3	$0(PA)	2	2		Synjardy XR *(>$730)*	
3	$0(PA)	2	2		Trijardy XR *(>$730)*	
3	$0(PA)	2(ST)	2		Glyxambi *(>$730)*	
	$0(PA)	(ST)			Steglatro *($>425)*	
	$0(PA)				Segluromet *(>$425)*	
					Steglujan *(>$660)*	
		4 (ST)		**GLP-1 Receptor agonists** **May delay the progression of diabetic nephropathy*	Adlyxin *(>$800)*	1. Risk of gallbladder disease or pancreatitis (acute and chronic) 2. C/I in patient or family history of medullary thyroid cancer or MEN2 3. Ozempic – monitor for worsening diabetic retinopathy 4. Ozempic: SUSTAIN-6 showed it had a lower incidence of nephropathy (driven by preventing new microalbuminuria) in 1 out of 44 pts over two years. FLOW trial demonstrated 24% decreased risk of major kidney disease events over 3.4 years in pts with DM & CKD 5. Victoza: LEADER showed it had a lower incidence of nephropathy (driven by preventing new onset macroalbuminuria) in 1 out of 67 pts over 4 years; Victoza is FDA
	$0(PA)	2(PA)			Byetta *(<$1,000)*	
4	$0(PA)	2(PA)	2(PA)		Bydureon BCise*(>$1,000)*	
3	$0(PA)	2(PA)	2(PA)		Mounjaro *(>$1,300)*	
3	$0(PA)	2(PA)	2 (PA)		*Ozempic *(>$1,500)*	

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3	$0(PA)	2(PA)	2(PA)		Rybelsus *(>$1,150)*	approved for reducing the combined endpoints of CV death, MI, or stroke in DM pts with CV disease (LEADER) 6. Mounjaro - SURPASS-4 post-hoc analysis showed a lower occurrence of the kidney composite (eGFR decline, ESRD, death due to kidney failure, & new onset macroalbuminuria) verses insulin glargine 7. Trulicity is FDA approved for reducing the combined endpoints of CV death, MI, or stroke in DM patients with CV disease or at high CV risk (REWIND)
3	$0(PA)	2(PA)	2 (PA)		Trulicity *(>$1,150)*	
3		2(PA) (2pk) 3 (PA) (3pk)			*Liraglutide *(>$625 2-pk, >$950 3-pk)*	

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8.) *Expressscripts.com, accessed by S.Tripode on 12/05/24*
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