Pharmacy Medical Necessity Guidelines: Ferric Citrate (Auryxia™)

Effective: June 9, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Auryxia (ferric citrate) is a phosphate binder indicated for the control of serum phosphorus levels in adult patients with chronic kidney disease receiving dialysis. Auryxia is also an iron replacement product indicated for the treatment of iron deficiency of anemia in adult patients with chronic kidney disease not on dialysis.

COVERAGE GUIDELINES

The plan may authorize coverage of **Auryxia (ferric citrate)** for Members when the following criteria are met and limitations do not apply:

Hyperphosphatemia

1. The Member is diagnosed with hyperphosphatemia associated with chronic kidney disease and is receiving dialysis

AND

2. The Member has had an inadequate response or intolerance to, or the provider indicates clinical inappropriateness of therapy with, at least two generic phosphate binders

Iron Deficiency Anemia

1. The Member is diagnosed with iron deficiency of anemia with chronic kidney disease

AND

2. The Member is not receiving dialysis

AND

3. The Member has had an inadequate response or intolerance to a trial of at least two alternative oral iron therapies (e.g., ferrous sulfate, ferrous fumarate, ferrous gluconate)

LIMITATIONS

None

CODES

None

REFERENCES

1. Auryxia (ferric citrate) [prescribing information]. Cambridge, MA: Keryx Biopharmaceuticals, Inc.; January 2024.
2. Quarles LD, Kendrick J. Management of hyperphosphatemia in adults with chronic kidney disease. UpToDate. Available at: www.uptodate.com. Accessed 18 April 2024.
3. Berns JS. Treatment of iron deficiency in patients with nondialysis chronic kidney disease (CKD). UpToDate. Available at: www.uptodate.com. Accessed 18 April 2024.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. August 8, 2023: No changes.
2. May 14, 2024: Effective August 1, 2024, updated RxUM fax number and previous trial language.
3. May 13, 2025: No changes
4. June 9, 2026: Administrative update to clarify separate criteria for hyperphosphatemia and iron deficiency anemia. No criteria changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLink[SM] Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.
For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services