UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1455-2
Program	Prior Authorization/Notification
Medication	Vafseo® (vadadustat)
P&T Approval Date	9/2024, 9/2025
Effective Date	12/1/2025

1. Background:

Vafseo® (vadadustat) is a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor indicated for the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months.

Limitations of Use

- Vafseo has not been shown to improve quality of life, fatigue, or patient well-being.
- Vafseo is not indicated for use as a substitute for transfusion in patients requiring immediate correction of anemia or in patients with CKD not on dialysis.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Vafseo** will be approved based on **both** of the following criteria:

   a. Diagnosis of anemia due to chronic kidney disease (CKD)

   -AND-

   b. Patient has been receiving dialysis for at least three months

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Vafseo** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Vafseo therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class

4. References:

1. Vafseo [package insert]. Cambridge, MA: Akebia Therapeutics, Inc.; March 2024.

Program	Prior Authorization/Notification – Vafseo (vadadustat)
Change Control	
9/2024	New program.
9/2025	Annual review with no changes to coverage criteria.