



# National Kidney Foundation™

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December 6, 2007

United States Pharmacopeia  
Model Guidelines Submissions  
Department of Information Development  
12601 Twinbrook Parkway  
Rockville, MD 20852

Dear Sir or Madam:

Chronic Kidney Disease (CKD) is a public health problem in the United States, affecting an estimated 13 % of the US adult population. (1) Moreover, CKD is part of a constellation of diseases and Americans with CKD also often suffer from diabetes, hypertension, and other cardiovascular conditions. Furthermore, CKD multiplies the risk of those other diseases which may take their toll before kidney disease progresses to kidney failure. Therefore, the comments of the National Kidney Foundation (NKF) on the Draft Medicare Part D Model Guidelines Version 4.0 address the need to ensure access to appropriate medications for Medicare beneficiaries in all stages of CKD, including, but not limited to, those with End Stage Renal Disease (ESRD), who require dialysis or transplantation to survive. Care of individuals with CKD is different from the general population with hypertension or diabetes including: lower blood pressure targets; more complex blood pressure management (typically requiring multiple drug types); use of specific agents, e.g. angiotensin converting enzyme inhibitors/angiotensin receptor blockers for proteinuria attenuation; dyslipidemia management requiring attention to drug interactions; and more complex glycemic control.

Therefore, we commend USP for including direct renin inhibitors as a Formulary Key Drug Type under Cardiovascular Agents. Patients with impaired kidney function usually require 3 or more drugs to treat hypertension. Aliskiren, a direct renin-inhibitor, expands the therapeutic options to treat hypertension in individuals with CKD. Conversely, we continue to suggest, as indicated in our comments on the first three draft USP Guidelines for the Medicare Prescription Drug Benefit, that the model formulary include fixed dosed combinations of *antihypertensive* drugs. Such combination drugs should facilitate patient adherence to the course of treatment recommended by their health care providers. (Please see NKF letters dated September 17, 2004, December 21, 2005, and December 7, 2006.)

We also appreciate the inclusion of sevelamer carbonate as a phosphate binder in the **USP DRUG LIST TABLE VERSION 4.0**. This is a new agent that should be available to kidney patients if prescribed by their physicians.

We make the following specific recommendations with regard to the needs of Medicare beneficiaries with End-Stage Renal Disease and those with advanced CKD and note that the Medicare Part D manual, pages 16-17, states that formularies should afford access to drugs and drug classes addressed in widely accepted treatment guidelines for End Stage Renal Disease which are indicative of best practices.

### Immune Suppressants

We reiterate our concern over USP's decision to remove drugs to prevent rejection of transplanted organs from the Medicare Model Guidelines Drug Table. Since most transplant recipients need to take several immune suppressants in combination, it is imperative that all immunosuppressive drug formulations are accessible through Medicare Part D formularies. Medicare Part D plans may misinterpret the fact that there is only one type of anti-rejection drug included in the "Immune Suppressants" pharmacologic class and leave widely prescribed immunosuppressants off of their drug formularies.

Under 120 Pharmacologic Class "Immune Suppressants" two more Formulary Key Drug Types should be added. The first new category would be "Immune Suppressants, Calcineurin Inhibitors" and under that category, tacrolimus and cyclosporine should be listed. The second category would be "Immune Suppressants, mTOR inhibitors" and under that category sirolimus should be listed.

Additional anti-rejection drugs should be listed in the Drug Table. Under 41, Pharmacologic Class "Antimetabolites" and Formulary Key Drug Type "Purine Analogs and Related Inhibitors," azathioprine should be included. In addition under Pharmacologic Class "Antimetabolites," another Formulary Key Drug Type should be added: "Antimetabolites, Antiproliferative," and mycophenolate mofetil and mycophenolate acid should be listed under this category.

### Category 142 (Therapeutic Nutrients/Minerals/Electrolytes)

Part D formularies should include iron products to treat, in combination with erythropoiesis stimulating agents, the anemia that Medicare beneficiaries with chronic kidney disease experience. Iron products used to treat anemia should be recognized in a special category, and not as a vitamin/mineral.

Oral iron products are utilized by chronic kidney disease patients not treated with dialysis or transplantation, home hemodialysis patients and home peritoneal dialysis patients. Without Medicare Part D access to these oral iron preparations, patients may choose not to purchase these medications. Failure to cover oral iron supplementation, but to provide coverage of erythropoiesis-stimulating agents (ESAs) is counterintuitive. Without adequate iron supplementation, many CKD patients will not have an optimal response to ESAs. Oral iron is inexpensive while ESAs are expensive. Oral iron products should be covered to ensure cost-effective treatment of CKD anemia. We also suggest that the following i.v. iron products: iron

dextran, iron sucrose and ferric gluconate, be included under Part D since they can be administered to Medicare beneficiaries with ESRD who live in long term care facilities. Failure to cover iron supplementation may be cost-ineffective, potentially promoting increased utilization of erythropoiesis stimulating agents.

Category 143 (Vitamins)

We recommend a formulary key drug type for the vitamin preparations that have been developed specifically for dialysis patients, known as “renal vitamins.” Dialysis patients, and patients with advanced CKD, need special vitamins because dietary restrictions may limit their intake of essential vitamins and minerals; vitamin and minerals may be depleted during dialysis treatment; and because most standard vitamins contain high levels of fat soluble vitamins and certain minerals that can be toxic to people with impaired kidney function. Standard vitamins include too much vitamin A for a dialysis patient. Conversely, the amount of vitamin B12 and folate in standard vitamins is often inadequate. In a recent observational study, use of water-soluble vitamins by hemodialysis patients was associated with a substantially and significantly lower risk for mortality. (2)

Sincerely,



Allan J. Collins, MD  
President  
National Kidney Foundation, Inc.

(1) Josef Coresh, et al. “Prevalence of Chronic Kidney Disease in the United States.” *JAMA*, November 7, 2007 – Vol 298, No 17, pp. 2038-2047.

(2) Rachel B. Fissell, et al. “International Variation in Vitamin Prescription and Association with Mortality in the Dialysis Outcomes and Practice Patterns Study (DOPPS).” *American Journal of Kidney Diseases*, Vol 44, No 2 (August), 2004: pp. 293-299.