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FORMULARY FRONTLINES[®]

Comparative Review of Chronic Kidney
Disease Therapeutics Coverage Across
3 Major Health Plans

Chronic kidney disease (CKD) remains one of the most clinically and economically significant conditions in managed care. Affecting an estimated 35–37 million adults in the US, CKD is closely associated with diabetes, hypertension, and cardiovascular disease and is a major driver of hospitalization and progression to end-stage renal disease (ESRD).¹ The financial burden is substantial, with total Medicare spending for beneficiaries with CKD and ESRD continuing to exceed \$130 billion annually, driven largely by complications, dialysis, and inpatient care.²

The therapeutic landscape continues to evolve. Sodium-glucose cotransporter-2 (SGLT2) inhibitors have expanded beyond diabetes into broader CKD populations, demonstrating reductions in renal decline and cardiovascular outcomes.³ At the same time, newer add-on therapies, including nonsteroidal mineralocorticoid receptor antagonists such

as finerenone, introduce additional clinical benefit but also increase complexity in treatment sequencing and cost management.

This expanding treatment paradigm creates a tension for payers: balancing broad access to foundational therapies across a large population while applying appropriate controls to newer, higher-cost adjunctive treatments. Against this backdrop, formulary strategies vary across health plans, particularly in tier placement and utilization management.

This Formulary Frontlines report compares coverage across BCBS, Cigna, and UnitedHealthcare (UHC) to evaluate how payers are operationalizing access within a high-prevalence, high-cost therapeutic category.

Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors

Tier 1-5 Plan			
Drug	Tier	Plan	Requirements/Limits
Dapagliflozin propanediol (FARXIGA) oral tablet 5 mg, 10 mg	2	BCBS ^{4,a}	ST
Empagliflozin (JARDIANCE) oral tablet 10 mg, 25 mg	2	BCBS ^{4,a}	ST
Dapagliflozin propanediol (FARXIGA) oral tablet	3	UnitedHealthcare ^{5,b}	QL
Empagliflozin (JARDIANCE) oral tablet	3	UnitedHealthcare ^{5,b}	QL

Across the 3 health plans evaluated, SGLT2 inhibitors are consistently covered but managed.

BCBS places both FARXIGA and JARDIANCE on Tier 2 with step therapy requirements, reflecting preferred positioning with sequencing controls.⁴ Cigna similarly places these agents on Tier 2 but layers additional quantity limits, introducing further utilization oversight.⁵

UnitedHealthcare places both agents on Tier 3, indicating preferred brand status but higher cost-sharing relative to BCBS and Cigna. In addition, quantity limits are applied, reinforcing control over utilization.⁶

Overall, all 3 plans recognize SGLT2 inhibitors as foundational CKD therapies. However, consistent use of step therapy and quantity limits highlights payer efforts to manage population-level cost exposure while maintaining access.

Tier 1-3 Plan			
Drug	Tier	Plan	Requirements/Limits
Dapagliflozin (FARXIGA)	2	Cigna ^{6,c}	ST; QL
Empagliflozin (JARDIANCE)	2	Cigna ^{6,c}	ST; QL

^a Level or Tier 1: Preferred, low-cost generic drugs; Level or Tier 2: Preferred brand drugs; Level or Tier 3: non-preferred drugs and all compounded medications; Level or Tier 4: preferred specialty drugs; Level or Tier 5: non-preferred specialty drugs.⁴

^b Level or Tier 1: lower-cost, commonly used generic drugs; Level or Tier 2: many generic drugs; Level or Tier 3: many common brand name drugs, called preferred brands and some higher-cost generic drugs. Insulin drugs with \$25 max copay; Level or Tier 4: Non-preferred generic and non-preferred brand name drugs. Level or Tier 5: Unique and/or very high-cost brand and generic drugs.⁵

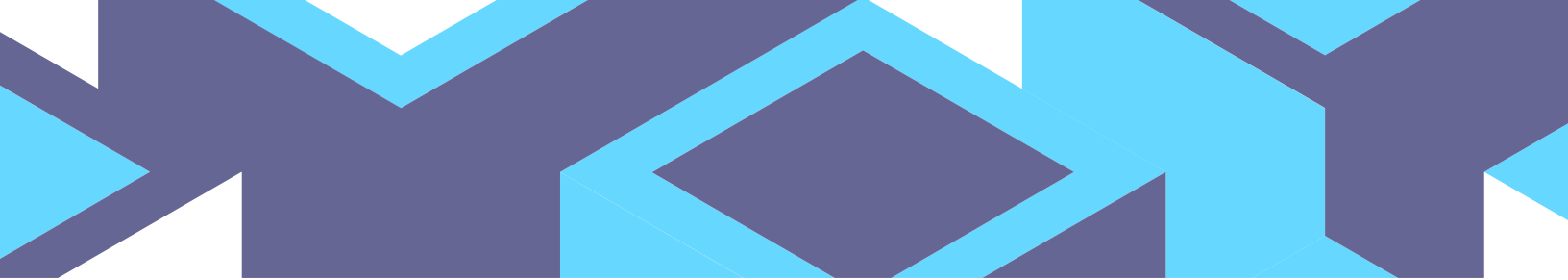
^c Level or Tier 1: Generic drugs (low-cost); Level or Tier 2: preferred brand drugs (preferred), and some high-cost generic drugs; Level or Tier 3: non-preferred brand name drugs.⁶

Abbreviations: BCBS, Blue Cross Blue Shield; ST, step therapy; QL, quantity limit.

Mineralocorticoid Receptor Antagonists

Tier 1-5 Plan			
Drug	Tier	Plan	Requirements/Limits
Spironolactone oral tablet	1	UnitedHealthcare ^{5,a}	
Eplerenone oral tablet	3	UnitedHealthcare ^{5,a}	
Finerenone (KERENDIA) oral tablet 10 mg, 20 mg	4	UnitedHealthcare ^{5,a}	PA; DL; QL

Tier 1-3 Plan			
Drug	Tier	Plan	Requirements/Limits
Finerenone (KERENDIA)	2	Cigna ^{6,b}	PA; QL



^a Level or Tier 1: lower-cost, commonly used generic drugs; Level or Tier 2: many generic drugs; Level or Tier 3: many common brand name drugs, called preferred brands and some higher-cost generic drugs. Insulin drugs with \$25 max copay; Level or Tier 4: Non-preferred generic and non-preferred brand name drugs. Level or Tier 5: Unique and/or very high-cost brand and generic drugs.⁵

^b Level or Tier 1: Generic drugs (low-cost); Level or Tier 2: preferred brand drugs (preferred), and some high-cost generic drugs; Level or Tier 3: non-preferred brand name drugs.⁶

Abbreviations: BCBS, Blue Cross Blue Shield; DL, dispensing limit; PA, prior authorization; QL, quantity limit.

Coverage of mineralocorticoid receptor antagonists demonstrates greater variation, particularly for newer agents. However, across the 3 health plans evaluated, coverage of mineralocorticoid receptor antagonists varies significantly, with BCBS the most restrictive.⁴ Based on this review, BCBS does not appear to provide coverage for agents within this class, suggesting that members may need to pursue formulary exceptions or alternative therapies. This represents a meaningful access barrier relative to the other plans.

Cigna places finerenone on Tier 2 with prior authorization and quantity limits, suggesting preferred access with targeted clinical criteria.⁵ In contrast, UnitedHealthcare places finerenone on Tier 4 with prior authorization, dispensing limits, and quantity limits, indicating a more restrictive approach.⁶

Generic agents such as spironolactone remain broadly accessible, with UnitedHealthcare placing it on Tier 1, reflecting low-cost, first-line use.⁶

These differences highlight a key trend: while established therapies remain widely accessible, newer add-on treatments are subject to tighter clinical and financial controls.

Potassium Binders

Tier 1-5 Plan			
Drug	Tier	Plan	Requirements/Limits
Sodium polystyrene sulfonate oral powder	3	UnitedHealthcare ^{5,a}	
Sodium zirconium cyclosilicate (LOKELMA) oral packet	4	UnitedHealthcare ^{5,a}	DL; QL
Patiromer (VELTASSA) oral packet	4	UnitedHealthcare ^{5,a}	DL; QL
Tier 1-3 Plan			
Drug	Tier	Plan	Requirements/Limits
Lokelma	2	Cigna ^{5,b}	
Veltassa	2	Cigna ^{5,b}	

^a Level or Tier 1: lower-cost, commonly used generic drugs; Level or Tier 2: many generic drugs; Level or Tier 3: many common brand name drugs, called preferred brands and some higher-cost generic drugs. Insulin drugs with \$25 max copay; Level or Tier 4: Non-preferred generic and non-preferred brand name drugs. Level or Tier 5: Unique and/or very high-cost brand and generic drugs.⁵

^b Level or Tier 1: Generic drugs (low-cost); Level or Tier 2: preferred brand drugs (preferred), and some high-cost generic drugs; Level or Tier 3: non-preferred brand name drugs.⁶

Abbreviations: BCBS, Blue Cross Blue Shield; DL, dispensing limit; QL, quantity limit.

Potassium binders illustrate a more traditional formulary approach. However, across the 3 health plans evaluated, coverage of potassium binders varies meaningfully, with BCBS the most restrictive.⁴ Based on this review, BCBS does not appear to provide coverage for agents within this class, suggesting that members may need to pursue formulary exceptions or alternative therapies. This creates a clear access gap relative to the other plans.

Cigna places branded agents such as LOKELMA and VELTASSA on Tier 2, indicating preferred brand status without extensive administrative barriers.⁵

UnitedHealthcare places these same agents on Tier 4 with dispensing and quantity limits, reflecting higher cost-sharing and tighter management.⁶ Generic sodium polystyrene sulfonate remains available at a lower tier, reinforcing a cost-first strategy.

Across plans, access is preserved, but tier placement signals clear preference for lower-cost options.

Phosphate Binders

Tier 1-5 Plan			
Drug	Tier	Plan	Requirements/Limits
Sevelamer carbonate oral tablet	1	BCBS ^{4,a}	
Sevelamer carbonate oral tablet	1	UnitedHealthcare ^{5,b}	

Tier 1-3 Plan			
Drug	Tier	Plan	Requirements/Limits
Sevelamer	1	Cigna ^{5,c}	
Velphoro	2	Cigna ^{5,c}	

^a Level or Tier 1: Preferred, low-cost generic drugs; Level or Tier 2: Preferred brand drugs; Level or Tier 3: non-preferred drugs and all compounded medications; Level or Tier 4: preferred specialty drugs; Level or Tier 5: non-preferred specialty drugs.⁴

^b Level or Tier 1: lower-cost, commonly used generic drugs; Level or Tier 2: many generic drugs; Level or Tier 3: many common brand name drugs, called preferred brands and some higher-cost generic drugs. Insulin drugs with \$25 max copay; Level or Tier 4: Non-preferred generic and non-preferred brand name drugs. Level or Tier 5: Unique and/or very high-cost brand and generic drugs.⁵

^c Level or Tier 1: Generic drugs (low-cost); Level or Tier 2: preferred brand drugs (preferred), and some high-cost generic drugs; Level or Tier 3: non-preferred brand name drugs.⁶

Abbreviations: BCBS, Blue Cross Blue Shield.

Phosphate binder coverage is broadly consistent across plans and reflects a mature therapeutic category.

All 3 plans place generic sevelamer on Tier 1, supporting low-cost, first-line access.⁴⁻⁶ Branded agents such as VELPHORO are placed on higher tiers, encouraging generic utilization without imposing significant administrative restrictions.

This approach suggests that management is driven primarily through cost-sharing rather than utilization controls.

Bottom Line

Across chronic kidney disease therapies, formulary access is broadly preserved—but increasingly structured.

SGLT2 inhibitors are consistently positioned as preferred therapies across all 3 plans, reinforcing their role as foundational treatment. However, step therapy and quantity limits are widely applied, reflecting payer efforts to manage utilization across a large patient population.

Add-on therapies such as finerenone introduce greater variability. While Cigna provides relatively favorable access with prior authorization, UnitedHealthcare applies more restrictive tier placement and utilization management, signaling heightened scrutiny of incremental cost and benefit.

Supportive therapies, including potassium and phosphate binders, remain widely accessible, with management driven primarily through tier placement and generic preference.

Taken together, these findings reinforce a broader theme: as CKD treatment evolves, payer strategy is shifting toward structured access models that prioritize foundational therapies while tightly managing adjunctive treatments. In a high-prevalence, high-cost disease area, tier placement and utilization management will continue to play a central role in balancing access, affordability, and total cost of care.

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