



Phosphate Binders

Therapeutic Class Review (TCR)

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FDA-APPROVED INDICATIONS

Drug	Manufacturer	Indication(s)
calcium acetate (Eliphos®) ¹	generic	Control of hyperphosphatemia in end stage renal failure; does not promote aluminum absorption
calcium acetate (PhosLo®) ²	generic	Phosphate binder indicated for the reduction of serum phosphorus in patients with end stage renal disease (ESRD)
calcium acetate (Phoslyra®) ³	Fresenius Medical Care	Phosphate binder indicated to reduce serum phosphorus in patients with end stage renal disease (ESRD)
ferric citrate (Auryxia™) ⁴	Keryx Biopharmaceuticals	Phosphate binder indicated for the control of serum phosphorus levels in patients with chronic kidney disease on dialysis
lanthanum carbonate (Fosrenol®) ⁵	Shire US	Phosphate binder indicated to reduce serum phosphate in patients with end stage renal disease (ESRD)
sevelamer hydrochloride (Renagel®) ⁶	Genzyme	Phosphate binder indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis
sevelamer carbonate (Renvela®) ⁷	generic, Genzyme	Phosphate binder indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis
sucroferric oxyhydroxide (Velphoro®) ⁸	Fresenius Medical Care	Phosphate binder indicated for the control of serum phosphorus in patients with chronic kidney disease (CKD) on dialysis

OVERVIEW

Chronic kidney disease (CKD) affects approximately 26 million Americans in the United States.⁹ As kidney function deteriorates, the ability to eliminate phosphorus declines, resulting in hyperphosphatemia, one of the complications of CKD. Elevated levels of phosphorus inhibit the conversion of 24-hydroxyvitamin D to 1,25-dihydroxyvitamin D (calcitriol). The reduction in calcitriol decreases intestinal absorption of calcium and eventually leads to hypocalcemia. In end stage renal disease (ESRD), patients are at risk for several complications of hyperphosphatemia, including the development of renal bone disease and extraosseous calcifications of soft tissue and vasculature. Hyperphosphatemia (greater than 6.5 mg/dL) is also associated with increased risk of death.^{10 11,12,13}

Direct stimulators of parathyroid hormone (PTH) secretion include hypocalcemia, low levels of calcitriol, and hyperphosphatemia. Secondary hyperparathyroidism contributes to abnormal bone metabolism observed in CKD. Management of renal osteodystrophy includes maintenance of calcium and phosphate balance, vitamin D supplementation, reducing patient exposure to aluminum, and, in some cases, parathyroidectomy.

Another complication of hyperphosphatemia is extraosseous calcifications of soft tissue and vasculature. Soft tissue calcifications can occur in vascular and cardiac tissue leading to increased morbidity and mortality.^{14,15} The calcium x phosphorus (Ca X P) product is calculated by using the patient's corrected serum calcium level and serum phosphorus level; the desired product level is less than 55 mg²/dL². Patients with elevated Ca X P values are at a significantly higher risk of death.¹⁶

The National Kidney Foundation released guidelines in 2003 regarding the management of hyperphosphatemia and bone-related disorders in patients with renal impairment. According to the National Kidney Foundation – Kidney Disease Quality Outcome Initiative (NKF-K/DOQI™), patients with CKD who are on dialysis should have serum phosphorus level maintained between 3.5 to 5.5 mg/dL (1.13 to 1.78 mmol/L).¹⁷ Treatment of hyperphosphatemia includes the reduction of dietary phosphorus, phosphate binding therapy, and removal of phosphorus by dialysis.^{18,19} Dietary phosphorus should be limited when serum phosphorus exceeds 5.5 mg/dL (1.78 mmol/L) in dialysis patients.²⁰ However, dietary restriction alone is rarely sufficient, and over 90 percent of patients with kidney failure require treatment with a phosphate binder.²¹ For patients with stage 3 or 4 CKD, calcium-based therapy is effective in lowering phosphate levels according to the NKF-K/DOQI guidelines (Evidence rating).²² For patients with kidney failure (stage 5 CKD), either calcium-based therapy or non-calcium, non-aluminum, non-magnesium therapy are effective in reducing phosphate (Evidence rating) and may be used as primary therapy (Opinion rating).

The Kidney Disease Improving Global Outcomes (KDIGO) 2012 clinical practice guidelines for the evaluation and management of CKD suggest that adult patients and pediatric patients in CKD stage 3 (recommendation 1C) and CKD stage 2 (recommendation 2D), respectively, should have their levels of calcium, phosphorus, PTH, and alkaline phosphatase activity monitored.²³ The frequency of monitoring depends on identified abnormalities, glomerular filtration rate (GFR) severity and abnormalities, and use of concomitant medications. It is also recommended that patients with stage 3-5 CKD, with and without dialysis, maintain phosphorus levels within normal range as numerous epidemiological studies show a positive correlation between higher serum phosphorus levels and relative risk of mortality, independent of CKD stage, as well as an increased risk for bone disease, vascular calcification, and cardiovascular disease. The guidelines recommend that patients with CKD stages 3-5 (recommendation 2D) and CKD stage 5D (dialysis; recommendation 2B) use phosphate-binding agents for the treatment of hyperphosphatemia. Studies have shown that all phosphate lowering medications (e.g., calcium salts, aluminum salts, magnesium salts, sevelamer HCl, and lanthanum carbonate) are effective in lowering serum phosphorus levels. In patients with CKD stages 3-5D and hyperphosphatemia, the guidelines suggest restricting the dose of calcium-based phosphate binders in the presence of persistent or recurrent hypercalcemia (recommendation 1B), arterial calcification (recommendation 2C), adynamic bone disease (recommendation 2C), and serum PTH levels that are persistently low (recommendation 2C). In patients with CKD stages 3-5D, the guidelines strongly recommend avoiding the long-term use of aluminum containing phosphate binders, as they may cause neurotoxicities and impair bone mineralization, and there is also no ability to predict a safe aluminum dose. Overall, the updated guidelines note there is insufficient comparative efficacy data on clinical outcomes to endorse the use or superiority of one phosphate binder medication over another. The selection of an appropriate phosphate binder should be individualized and based on various clinical parameters, not phosphorus lowering alone. In 2014, NKF-K/DOQI published commentary on the 2012 KDIGO CKD guidelines.²⁴ Overall the commentary agreed with most of the guideline statements.

Sucroferric oxyhydroxide (Velporo) and ferric citrate (Auryxia) were not available at the time these guidelines were developed. However, clinical trials of sucroferric oxyhydroxide versus active control (sevelamer hydrochloride and carbonate) have demonstrated the efficacious serum phosphorus lowering capabilities of sucroferric oxyhydroxide.²⁵ Similarly, studies have shown that ferric citrate, when compared to calcium acetate, and/or sevelamer carbonate, have had similar decreases in serum phosphorus levels.²⁶

Over-the-counter calcium acetate (Calphron® OTC) is a dietary supplement that binds dietary phosphate.²⁷ MagneBind® 400 Rx is a prescription dietary supplement with an off-label indication of hyperphosphatemia and nutritional supplementation.^{28,29} It is a tablet of calcium carbonate 200 mg, folic acid (vitamin B9) 1 mg, and magnesium carbonate 400 mg. Calphron OTC and MagneBind 400 Rx will not be included in this review as they are dietary supplements.

PHARMACOLOGY^{30,31,32,33,34,35,36,37}

Efforts to control hyperphosphatemia include a reduction in dietary intake of phosphate, inhibition of phosphate absorption via phosphate binders, and removal of phosphate through dialysis methods. Dialysis patients absorb 40 to 80 percent of their dietary phosphorus and often the rate of phosphate removal by dietary management or by dialysis is insufficient. Therefore, most renal failure patients on maintenance dialysis need to use phosphate binders in order to reduce the amount of dietary phosphate absorbed. Phosphate-binding agents decrease phosphorus absorption from the gastrointestinal (GI) tract by binding dietary phosphorus. Maintaining serum phosphorus below six mg/dL is generally considered a clinically acceptable outcome of treatment with phosphate binders.

Calcium-containing salts (Eliphos, PhosLo, and Phoslyra) not only maintain positive calcium balance but also bind with dietary phosphorus to create an insoluble calcium phosphate complex which is then eliminated through the feces. This process decreases the serum phosphorus concentration. Calcium and vitamin D analog supplementation may be necessary to slow or prevent renal bone disease.

Five non-calcium phosphate binders are now available and offer an alternative to calcium-based agents when hypercalcemia is present. Sevelamer (Renagel, Renvela) is a non-calcium, non-aluminum, non-magnesium, non-absorbable hydrogel that binds phosphorus. Sevelamer is available in two salt forms – sevelamer hydrochloride (Renagel) and sevelamer carbonate (Renvela). Sevelamer produces a similar reduction in serum phosphorus levels as calcium acetate, but it is less likely to induce hypercalcemia. Another phosphate-binding agent is lanthanum carbonate (Fosrenol). Lanthanum is a naturally occurring earth element with a high affinity for phosphorus. Lanthanum binds with phosphorus to form insoluble lanthanum phosphate.³⁸ The diminished absorption of dietary phosphate reduces serum phosphate and calcium phosphate levels. Sucroferric oxyhydroxide (Velporo) is a mixture of polynuclear iron (III)-oxyhydroxide, sucrose, and starches. Phosphate binding takes place by ligand exchange between hydroxyl groups and/or water in sucroferric oxyhydroxide and dietary phosphate in the aqueous environment of the GI tract. The bound phosphate is eliminated through the feces which in turn reduces serum phosphorus and calcium-phosphorus product levels. Ferric citrate (Auryxia) contains ferric iron which binds dietary phosphate in the GI tract and precipitates as ferric phosphate. Ferric phosphate is not absorbed and excreted in the stool, thereby decreasing the body's phosphate absorption and serum concentrations.

PHARMACOKINETICS^{39,40,41,42,43,44,45,46}

Absorption rate of calcium is dependent on numerous factors including the presence of vitamin D. Bioavailability of calcium acetate is 30 to 40 percent.

Sevelamer is not absorbed and is excreted in the feces. Sevelamer also reduces low-density lipoprotein (LDL-C) and total cholesterol by 15 to 31 percent. Absorption of fat soluble vitamins may be reduced as sevelamer binds to bile acids and interferes with fat absorption.

Lanthanum carbonate has an extremely low bioavailability (less than 0.002 percent) and is primarily excreted in the feces.⁴⁷ Lanthanum carbonate dissociates in the upper GI tract to release lanthanum ions that bind phosphate from food. Lanthanum forms insoluble complexes with phosphate that are eliminated via the feces. Systemic exposure to lanthanum was approximately 30 percent higher after administering lanthanum oral powder compared to lanthanum chewable tablets. However, systemic exposure from both formulations in the study was within the range seen in prior studies of the chewable tablets.

The active moiety of sucroferric oxyhydroxide, polynuclear iron (III)-oxyhydroxide, is virtually insoluble and not absorbed or metabolized; therefore, no pharmacokinetic studies have been performed.

Formal pharmacokinetic studies have not been performed with ferric citrate (Auryxia). However, serum iron parameter examinations have shown systemic absorption of iron.

CONTRAINDICATIONS/WARNINGS^{48, 49, 50, 51, 52, 53,54,55}

Calcium acetate (PhosLo, Eliphos, and Phoslyra) should not be administered in the presence of hypercalcemia. Additionally, calcium supplements should be avoided when using calcium acetate. Patients with ESRD are at increased risk of developing hypercalcemia when treated with calcium acetate. Chronic hypercalcemia could lead to complications, such as vascular calcification and other soft-tissue calcifications. The serum calcium times phosphate (Ca X P) product should not exceed 55 mg²/dL². If hypercalcemia develops, the dosage should be reduced or discontinued depending on the severity. Decreasing or discontinuing vitamin D therapy is advised, as well. If severe, acute hemodialysis may be needed. Calcium acetate therapy should be started at a low dose and increased with careful monitoring. Serum calcium should be monitored twice weekly early in treatment and serum phosphorus should also be monitored. In addition, hypercalcemia may aggravate digitalis toxicity. In the event of hypocalcemia, calcium supplementation and/or vitamin D sterols should be administered.

Sevelamer is contraindicated in the presence of bowel obstruction. Safety and efficacy of sevelamer in patients with dysphagia, swallowing disorders, and severe GI motility disorders, including severe constipation or major GI tract surgery, have not been established. Caution should be exercised when sevelamer is used in patients with these GI disorders. Dysphagia and esophageal tablet retention have been reported with the use of sevelamer tablets. Consider using sevelamer suspension in patients with swallowing disorders. Bowel obstruction and perforation have been reported with sevelamer use. Patients should have the following levels monitored while using sevelamer: bicarbonate, chloride, folic acid, and vitamins D, E, and K.

Lanthanum is contraindicated in bowel obstruction, ileus, and fecal impaction. Reports of serious cases of GI obstruction, ileus, and fecal impaction have been reported in connection with lanthanum, some requiring surgery or hospitalization. Risk factors for GI obstruction include alteration in GI anatomy (e.g., colon cancer, history of GI surgery); hypomotility disorders (e.g., constipation, ileus, diabetes); and concomitant medications (e.g., calcium channel blockers). However, some cases of GI obstruction were reported in patients with no history of GI disease. Patients are advised to thoroughly chew the tablet to reduce the risk of adverse GI events. If a patient has poor dentition, it is recommended that lanthanum be crushed thoroughly prior to administration or the oral powder formulation be used. Abdominal x-rays of patients taking lanthanum may have a radio-opaque appearance typical of an imaging agent. Patients with ulcerative colitis, acute peptic ulcer, Crohn's disease, or bowel obstruction

were not included in lanthanum clinical studies. Caution should be used in patients with these conditions taking lanthanum.

Sucroferric oxyhydroxide (Velphoro) has no known contraindications. Patients with peritonitis during peritoneal dialysis, a history of hemochromatosis or other iron accumulation diseases, or significant gastric or hepatic disorders, following gastrointestinal surgery, have not been included in clinical studies. Patients with these disorders should be closely monitored for medication effects and iron homeostasis.

Ferric citrate (Auryxia) is contraindicated in patients with iron overload syndromes due to the medication increasing iron absorption which could lead to increased serum iron and excessive increases in iron stores. Iron parameters (e.g., serum ferritin and TSAT) should be assessed prior to initiating therapy and thereafter. The medication should also be kept away from children as it could cause fatal poisoning in children under six years old.

DRUG INTERACTIONS^{56, 57, 58, 59, 60, 61,62,63}

Very limited drug interaction studies were performed with the agents. Calcium acetate may reduce the bioavailability of tetracyclines and fluoroquinolones (approximately 50 percent) since the medication binds to drugs with anionic function. For medications which binding of medications could cause clinically significant effects, it is recommended the other drug be taken one hour prior or three hours after taking calcium acetate. Monitoring blood levels of narrow therapeutic index drugs when taken concurrently with calcium acetate is recommended.

Sevelamer does not interact with digoxin, warfarin, enalapril, metoprolol, or ferrous sulfate.^{64,65,66} For medications which binding of medications could cause clinically significant effects, consideration should be given to the pharmacokinetics of the two drugs and whether the drug is an immediate- or extended-release product when determining administration times. Monitoring blood levels of narrow therapeutic index drugs when taken concurrently with sevelamer is recommended.

Lanthanum has the potential to bind to anionic groups in medications. The bioavailability of tetracyclines or fluoroquinolones may also decrease with concurrent use of lanthanum via this mechanism. In a single dose study of ciprofloxacin and lanthanum, a reduction of more than 50 percent of the absorption of ciprofloxacin was observed with concurrent administration.⁶⁷ Therefore, oral quinolones should be administered at least one hour before or four hours after lanthanum. Do not take thyroid hormone replacement therapy within two hours of dosing with lanthanum. Monitoring of TSH levels is recommended in patients receiving both medicinal agents. As a general precaution, drugs which interact with antacids should be administered at least two hours before or after lanthanum. For oral medications where a reduction in the bioavailability of the medication could cause a clinically significant effect on its safety or efficacy, consider separating the administration times based upon the pharmacokinetics of the medications (e.g., absorption characteristics, time to reach peak systemic levels, etc.) and whether the medication is an immediate- or extended-release product. Monitoring blood levels of narrow therapeutic index drugs when taken concurrently with lanthanum is recommended. Lanthanum does not interact with the CYP450 enzyme system.

No data are available on avoiding drug interactions when sucroferric oxyhydroxide (Velphoro) is taken with other oral medications. For oral medications where a reduction in the bioavailability of the medication could cause a clinically significant effect on its safety or efficacy, consider separating the administration times based upon the pharmacokinetics of the medications (e.g., absorption

characteristics, time to reach peak systemic levels, etc.) and whether the medication is an immediate- or extended-release product. Monitoring blood levels of narrow therapeutic index drugs when taken concurrently with sucroferric oxyhydroxide is recommended. Levothyroxine should not be prescribed with sucroferric oxyhydroxide.

No data exist on avoiding drug interactions with ferric citrate (Auryxia) and most other oral medications. Therefore, for oral medications where a reduction in the bioavailability would cause a clinically significant effect on its safety and efficacy, consider separating the dosing of the medications based on the drug's pharmacokinetics. Drugs that have a narrow therapeutic range should be monitored. It is known that doxycycline should be taken at least one hour before ferric citrate.

ADVERSE EFFECTS

Drug	Hypercalcemia	Diarrhea	Constipation	Nausea	Vomiting
calcium acetate (Eliphos) ⁶⁸	reported	nr	reported	reported	reported
calcium acetate (PhosLo) ⁶⁹ n=167	12.6	nr	reported	3.6	2.4
calcium acetate (Phoslyra) ⁷⁰	12.6*	*	*	3.6*	2.4*
ferric citrate (Auryxia)⁷¹	nr	21	8	11	7
lanthanum carbonate (Fosrenol) ⁷² n=180	nr	reported	reported	11	9
sevelamer hydrochloride (Renagel) ⁷³ n=99	nr	19	8	20	22
sevelamer carbonate (Renvela) ⁷⁴	nr	nr**	nr**	3**	3**
sucroferric oxyhydroxide (Velphoro) ⁷⁵	nr	4-24	nr	2-10	nr

Adverse effects are reported as a percentage. Adverse effects data are obtained from prescribing information and are not meant to be comparative or all inclusive. nr = not reported.

*No clinical trials have been performed with Phoslyra in the intended population. Because the dose and active ingredients of Phoslyra are equivalent to that of the calcium acetate gelcaps or tablets, the scope of the adverse reactions is anticipated to be similar.

**Adverse reaction data is limited on Renvela; however, based on the fact that it contains the same active ingredient as Renagel, the adverse reaction profiles should be similar.

Calcium acetate can cause hypercalcemia; therefore, monitoring of serum calcium is suggested. Symptoms of mild hypercalcemia (calcium 10.5 to 11.9 mg/dL) may include constipation, anorexia, nausea, and vomiting. Severe hypercalcemia (calcium greater than 12 mg/dL) may present as confusion, delirium, stupor, and coma. A reduction in calcium supplementation and dialysis will help reduce calcium levels.⁷⁶

Lanthanum deposits into bone over a period of several years. Long-term effects of lanthanum in bone are not known.⁷⁷ Paired bone biopsies (at baseline and at one or two years) in one study comparing lanthanum to calcium carbonate and another study comparing lanthanum to an alternative therapy showed no differences in the development of mineralization defects.⁷⁸

In a one-year study with 20 patients, lanthanum was shown to be deposited into bone in low concentrations.⁷⁹ After discontinuing lanthanum for two years, plasma and bone concentrations of lanthanum were still detectable although at lower concentrations than during active treatment. Bone biopsies from 105 patients treated for up to 4.5 years showed rising lanthanum levels. Estimated elimination half-life from bone ranged from two to 3.6 years.⁸⁰ A total of 22 patients have received lanthanum as a part of a clinical trial to monitor the efficacy and safety.⁸¹ Lanthanum doses were 2,250 to 3,000 mg per day for two-thirds of the patients. Efficacy in reducing serum phosphate and Ca X P product were maintained up to six years. Over the complete duration of therapy, treatment-related adverse effects occurred in 25.8 percent of patients and were primarily GI in nature. No new adverse effects were reported; no increase in the incidence of adverse events was reported. No evidence of adverse effects on the liver, bone, or the central nervous system was observed.

In studies, lanthanum oral powder resulted in higher GI adverse reactions such as nausea, diarrhea, and vomiting compared to lanthanum chewable tablets, 18 versus seven percent, respectively.

Sucroferric oxyhydroxide may cause dark colored feces (12 to 16 percent), which are common with oral iron preparations. Diarrhea associated with sucroferric oxyhydroxide use occurred soon after beginning treatment but resolved with continued use of the product.

Ferric citrate is associated with dark stools related to the iron content. Cough is also a commonly reported adverse reaction (six percent) in patients using ferric citrate.⁸²

SPECIAL POPULATIONS

Pediatrics^{83, 84, 85, 86, 87, 88,89, 90,91}

Safety and efficacy data for pediatric use of agents in this class have not been established. NKF-KDOQI 2005 guidelines for bone and mineral metabolism in pediatric patients on dialysis currently suggest the use of calcium based phosphate binders (Opinion rating), especially in infants and young children.⁹² In older children and adolescents, either sevelamer or calcium-based phosphate binders may be used (Opinion rating). European guidelines for prevention and treatment of renal osteodystrophy in children with CKD recommend calcium-based phosphate binders as first line therapy.⁹³ Sevelamer is suggested as an alternative therapy. Long-term effects on bone and safety profile of lanthanum in children are not yet available, but due to bone deposition and uncertain long-term effects on bone, lanthanum is not recommended in pediatric patients.

A randomized, open-label study with 18 children (ages less than one to 18 years) with renal insufficiency or CKD undergoing dialysis found that sevelamer and calcium acetate provided similar phosphorus control over eight weeks.⁹⁴ Patients underwent a two-week washout period then underwent treatment for eight weeks with either agent in a cross-over fashion. Doses were titrated as needed to achieve target levels of phosphorus. No difference in phosphorus levels between the two treatments were observed at eight weeks. In the crossover study, hypercalcemia occurred more frequently with calcium acetate ($p < 0.0005$) whereas metabolic acidosis was more common with sevelamer ($p < 0.005$). Total cholesterol (-27 percent) and LDL-C (-34 percent) were decreased significantly with sevelamer ($p < 0.02$, $p < 0.005$, respectively).

Pregnancy

Sucroferric oxyhydroxide and ferric citrate are Pregnancy Category B. All other agents in this class are Pregnancy Category C.^{95, 96, 97, 98, 99, 100,101,102}

DOSAGES

Drug	Initial Dosing	Maintenance Dosing	Availability
calcium acetate (Eliphos) ¹⁰³	1,334 mg with each meal	2,001 - 2,668 mg with each meal	667 mg tablet
calcium acetate (PhosLo) ¹⁰⁴	1,334 mg with each meal	2,001 - 2,668 mg with each meal	667 mg gelcap
calcium acetate (Phoslyra) ¹⁰⁵	10 mL with each meal	15 – 20 mL with each meal	667 mg per 5 mL solution
ferric citrate (Auryxia) ¹⁰⁶	2 tablets orally 3 times per day with meals	8 to 9 tablets per day, up to a maximum of 12 tablets daily	210 mg ferric iron (equivalent to 1 g ferric citrate)
lanthanum carbonate (Fosrenol) ¹⁰⁷	1,500 mg in divided doses daily given with or immediately after meals	1,500 - 3,000 mg in divided doses daily given with or immediately after meals Doses up to 4,500 mg were evaluated.	500, 750, and 1,000 mg chewable tablets 750 and 1,000 mg oral powder Tablets should be chewed completely; do not swallow intact tablet; consider crushing tablets prior to administration for patients with poor dentition or using the oral powder Oral powder should be sprinkled in applesauce or other similar food and taken immediately; do not attempt to dissolve in liquid
sevelamer hydrochloride (Renagel) ¹⁰⁸	800 – 1,600 mg 3 times daily with each meal based on serum phosphorus level	800 - 1,600 mg with each meal Dose may be increased or decreased by 1 tablet per meal at 2-week intervals based on serum phosphorus levels The maximum daily dose is 13 grams.	400, 800 mg tablets
sevelamer carbonate (Renvela) ¹⁰⁹	800 – 1,600 mg 3 times daily with each meal based on serum phosphorus level	1,600 – 2,400 mg 3 times daily with each meal Titrate dose by 800 mg 3 times per day with meals at 2-week intervals The maximum daily dose is 14 grams.	800 mg tablets 800 mg and 2,400 mg powder packets (powder does not dissolve in water and requires vigorous stirring prior to drinking and should be consumed within 30 minute, resuspend right before drinking)

Dosages (*continued*)

Drug	Initial Dosing	Maintenance Dosing	Availability
sucroferric oxyhydroxide (Velphoro) ¹¹⁰	500 mg 3 times daily with meals (1,500 mg daily)	1,500 – 3,000 mg daily Titrate dose by 500 mg per day with meals at 1-week intervals	500 mg chewable tablet Tablets must be administered with meals and chewed completely and not swallowed whole The tablets may be crushed to aid with chewing and swallowing

CLINICAL TRIALS

Search Strategy

Articles were identified through searches performed on PubMed and review of information sent by manufacturers. Search strategy included the FDA-approved use of all drugs in this class. Randomized, controlled, comparative trials are considered the most relevant in this category. Studies included for analysis in the review were published in English, performed with human participants and randomly allocated participants to comparison groups. In addition, studies must contain clearly stated, predetermined outcome measure(s) of known or probable clinical importance, use data analysis techniques consistent with the study question, and include follow-up (endpoint assessment) of at least 80 percent of participants entering the investigation. Despite some inherent bias found in all studies including those sponsored and/or funded by pharmaceutical manufacturers, the studies in this therapeutic class review were determined to have results or conclusions that do not suggest systematic error in their experimental study design. While the potential influence of manufacturer sponsorship and/or funding must be considered, the studies in this review have also been evaluated for validity and importance. Many of the trials with agents in this class were performed in an open-label manner; introduction of bias must be considered when evaluating study findings.

calcium acetate (PhosLo) and sevelamer hydrochloride (Renagel)

In an open-label, randomized trial, calcium acetate and sevelamer hydrochloride were compared for safety and efficacy in controlling hyperphosphatemia in hemodialysis patients.¹¹¹ Following a two-week washout period, 84 patients were randomized to calcium acetate or sevelamer for eight weeks. Patients were then crossed over to the alternate therapy following an additional two-week washout period. Doses of both agents were titrated to achieve appropriate phosphate levels. A similar decrease in phosphate levels was observed between the two therapies (sevelamer -2.0 ± 2.3 mg/dL versus calcium acetate -2.1 ± 1.9 mg/dL). Hypercalcemia (serum calcium >11 mg/dL) was observed in 22 percent of patients receiving calcium acetate. Five percent of patients receiving sevelamer developed serum calcium > 11 mg/dL (versus calcium acetate; $p < 0.01$), and the incidence was not different from the incidence of hypercalcemia during the washout period. A mean reduction of LDL-C of 24 percent was observed with sevelamer treatment.

The Calcium Acetate Renagel Evaluation (CARE) study was an evaluation of calcium acetate and sevelamer to see which therapy achieved the treatment goals of phosphorus (≤ 5.5 mg/dL) and the Ca X P product (≤ 55 mg²/dL²).¹¹² One hundred hemodialysis patients were randomized in the double-blind, eight-week trial. Patients treated with calcium acetate achieved lower serum phosphorus

(difference of -1.08 mg/dL, $p=0.0006$), higher serum calcium (difference of +0.63mg/dL, $p<0.0001$), and lower Ca X P product (difference of $-6.1 \text{ mg}^2/\text{dL}^2$) than the sevelamer-treated patients based on time-averaged concentrations for weeks one to eight. For each week, calcium acetate-treated patients were 20 to 24 percent more likely to be at goal for phosphate levels and 15 to 20 percent more likely to be at goal for the Ca X P product. Hypercalcemia was more common with calcium acetate (OR 6.1, 95% confidence interval [CI], 2.8-13.3, $p<0.0001$). At week eight, intact PTH levels were not significantly different.

sevelamer hydrochloride (Renagel) and calcium therapy

An open-label study evaluated 55 hemodialysis patients to determine the effects of sevelamer hydrochloride with and without calcium supplementation on serum phosphorus, calcium, and PTH.¹¹³ Patients were randomized following a two-week washout period to sevelamer or sevelamer with 900 mg of elemental calcium daily on an empty stomach. Forty-nine percent of all patients were also taking vitamin D metabolites. Efficacy of treatment in reducing serum phosphorus was similar for both groups. An insignificant increase in serum calcium occurred in the sevelamer plus calcium group. Non-users of vitamin D metabolites randomized to sevelamer plus calcium had a significant decrease in PTH ($p=0.006$) compared to sevelamer therapy alone. The sevelamer plus calcium group showed decreasing PTH levels throughout the study. All therapies were well tolerated.

The Dialysis Clinical Outcomes Revisited (DCOR) study was an open-label, prospective, randomized, controlled, three-year trial comparing sevelamer and calcium-based phosphate binders (PhosLo or calcium carbonate) for all-cause mortality and cause-specific mortality (cardiovascular mortality, infection, and other causes) in 2,103 patients.¹¹⁴ Patients were followed for up to 45 months. Forty-three percent of patients enrolled were followed for more than two years, and 1,068 patients completed the study. Seventy percent of the calcium group took PhosLo tablets; the remaining 30 percent took calcium carbonate. The mean prescribed dose was 5.3 g calcium acetate, 4.9 g calcium carbonate, and 6.9 g sevelamer. The primary endpoint was all-cause mortality, and no difference between the two groups was observed (relative risk 0.93, 95% CI, 0.79-1.1; $p=0.4$). An evaluation of patients who completed at least two years in the study (43 percent) revealed a difference in all-cause mortality favoring sevelamer ($p=0.02$). Deaths were reported in 26 ($n=142$) and 27 ($n=147$) percent of the sevelamer and calcium-based groups, respectively. Overall cardiovascular mortality ($p=0.53$) was similar between the two groups. When evaluating cardiovascular mortality and age (> 65 years or < 65 years), all-cause mortality and cardiovascular mortality were both significantly lower with sevelamer in the older population compared to the calcium group (both $p=0.02$). The time-weighted mean serum calcium values, total cholesterol, and LDL-C values were significantly lower in the sevelamer group (all $p<0.0001$). The Ca X P product was similar in both groups ($p=0.60$).

As a secondary analysis, hospitalization and cardiovascular morbidity were extracted from a merger of the DCOR study patient data and the Centers for Medicare and Medicaid Services (CMS) ESRD database.¹¹⁵ Patients included in the analysis used Medicare as the primary payer for treatment. Outcome parameters and cardiovascular comorbidity assessments were derived from Medicare claims data. A greater percentage of calcium-treated patients had atherosclerotic heart disease. Sevelamer had a positive effect on hospitalization days ($p=0.009$) and the multiple hospitalization rates ($p=0.046$) compared to the calcium-based binder group. No significant effect was seen in all-cause hospitalization rate or cardiovascular morbidity over the study time frame. Early discontinuation was similar in both

groups (sevelamer n=502; calcium n=533, p=0.15). The lead author disclosed support from the manufacturer of sevelamer.

A randomized (1:1), 36 month, open-label, multicenter study was performed to assess the impact of sevelamer hydrochloride (n=232) versus calcium carbonate (n=234) on cardiovascular death due to arrhythmias, all-cause cardiovascular death, and all-cause death in adult patients (n=466) with CKD stage 5 new to hemodialysis.¹¹⁶ The average doses of sevelamer and calcium were $4,300 \pm 1,400$ (median 4,800) mg daily and $2,200 \pm 1,000$ (median 2,000) mg daily, respectively, and investigators were allowed to adjust dosing, as needed, in order to achieve a serum phosphorus level of 2.7-5.5 mg/dL. At the conclusion of the study, patients treated with sevelamer (4.2 ± 1.2 ; -1.37 ± 1.93 change from baseline; $p < 0.001$) had lower serum phosphate levels compared to patients treated with calcium carbonate (4.8 ± 1.1 ; -0.10 ± 1.67 change from baseline; $p = 0.4$). Patients were monitored for up to 36 months and 128 deaths were reported at follow up. The study concluded that sevelamer-treated patients had a substantial reduction in risk of cardiovascular death due to cardiac arrhythmias ($p < 0.001$) compared to calcium treated patients. There were two and 27 patients who had cardiovascular deaths due to cardiac arrhythmias in the sevelamer and calcium group, respectively, which correlates with a greater than ten-fold reduction in risk for experiencing a lethal arrhythmia (95% CI; $p < 0.001$). Likewise, nine and 80 patients suffered from an all-cause cardiovascular death in the sevelamer and calcium treated group, respectively, which also correlates with a ten-fold risk reduction (95% CI; $p < 0.001$). All-cause mortality was also reduced in the sevelamer treated patients ($p < 0.001$). Overall, the study concluded that sevelamer reduces cardiovascular and all-cause mortality in patients with CKD stage 5.

sevelamer hydrochloride (Renagel) and sevelamer carbonate (Renvela)

In a double-blind, randomized, cross-over trial, sevelamer carbonate and sevelamer hydrochloride were compared in 79 hemodialysis patients for effects on serum phosphorus, lipids, and bicarbonate levels.¹¹⁷ Patients received eight weeks of treatment followed by eight weeks of the alternative treatment. The mean serum phosphorus was 4.6 ± 0.9 and 4.7 ± 0.9 mg/dL during sevelamer carbonate and sevelamer hydrochloride treatment, respectively. Mean total cholesterol and LDL-C were 144 and 59.5 mg/dL, respectively, during sevelamer carbonate treatment and 139 and 56 mg/dL, respectively, during sevelamer hydrochloride treatment. Serum bicarbonate levels increased by 1.3 mEq/L during sevelamer carbonate treatment. Fewer gastrointestinal adverse events were observed with sevelamer carbonate.

Another randomized, parallel, open-label study evaluated once-daily sevelamer carbonate powder for oral suspension versus three-times daily sevelamer hydrochloride tablets in hemodialysis patients.¹¹⁸ After an initial two-week washout, patients were randomly assigned to one of these therapies and evaluated for change in serum phosphorus levels from baseline to 24 weeks after therapy initiation. Phosphorus level decreased 2.0 ± 1.8 mg/dL for sevelamer carbonate and 2.9 ± 1.3 mg/dL for sevelamer hydrochloride ($p < 0.001$). Adverse event rates were similar between the groups with a greater percentage of treatment-related upper gastrointestinal events occurring with the carbonate product.

lanthanum (Fosrenol) and calcium carbonate

In a phase III, open-label study, lanthanum and calcium carbonate were compared for the effects on renal osteodystrophy in 98 dialysis patients.¹¹⁹ Patients were randomized to lanthanum or calcium

carbonate following a baseline bone biopsy. Bone biopsies were also evaluated after one year. Periodic assessments of electrolytes and adverse effects were recorded. At one year, 63 sets of bone biopsies were available. Serum phosphate was well controlled in both groups. Hypercalcemia was reported less often with lanthanum than calcium carbonate (six and 49 percent, respectively). Subtypes of renal osteodystrophy at baseline were similar in both groups with the mixed type being most common. The percentage of patients with adynamic bone, osteomalacia, or hyperparathyroidism was reduced by lanthanum therapy from 36 to 18 percent over one year. The calcium group saw an increase from 43 percent to 53 percent of patients with evidence of adynamic bone, osteomalacia, or hyperparathyroidism after one year. No aluminum-type effects on bone were seen with lanthanum use. Adverse effects were mostly GI in nature. Both groups had similar discontinuation rates.

A randomized, open-label trial compared lanthanum and calcium carbonate for control of serum phosphate levels over 20 weeks.¹²⁰ Patients (n=800) underwent a washout period and then were randomized to lanthanum or calcium carbonate. Patients completed a five-week dose titration period. Control of phosphate levels (≤ 5.58 mg/dL) was achieved by 65.8 and 63.9 percent of lanthanum- and calcium-treated patients, respectively, during 20 weeks of active treatment. Hypercalcemia was reported in 20.2 percent of calcium-treated patients compared to 0.4 percent of patients receiving lanthanum. The Ca X P product was slightly better controlled with lanthanum. The most common daily dose of lanthanum was 1,500 mg with a range of 375 to 3,000 mg per day. The most frequently used calcium carbonate daily dose was 3,000 mg (1,200 mg elemental calcium) with a range of 1,500 to 9,000 mg per day.

The above evaluation by Hutchinson and colleagues was extended an additional six months and then two years.¹²¹ Patients on lanthanum continued the maintenance dose as established in the previous study. Patients originally assigned to the calcium group were switched to lanthanum and underwent dose titration over five weeks. A total of 518 patients entered the six-month extension. Mean serum phosphorus throughout the six-month study extension was 5.5 mg/dL and 5.7 mg/dL in the lanthanum group and the group that switched from calcium to lanthanum, respectively. Hypercalcemia was reported in 2.7 percent of patients. A total of 161 patients entered the two-year extension phase; patients underwent a dose titration to achieve acceptable phosphorus control. Ninety patients completed the two years, and 46 of the patients were from the original lanthanum group. At the end of two years, 59 percent of the 90 remaining patients had serum phosphorus levels ≤ 5.6 mg/dL. The most common adverse events were GI related.

lanthanum (Fosrenol) and sevelamer hydrochloride (Renagel)

A crossover study evaluated lanthanum and sevelamer hydrochloride in the reduction of serum phosphorus in hemodialysis patients.¹²² This study began with an initial two- to three-week washout period, followed by randomization to either lanthanum (2,250 to 3,000 mg/day) or sevelamer (4,800 to 6,400 mg/day). Patients completed four weeks of the initial therapy before a second washout period and conversion to the alternative product. While lanthanum was shown to reduce serum phosphorus by 1.7 mg/dL, compared with 1.4 mg/dL for sevelamer, this difference was not statistically significant in the primary analysis. Lanthanum did demonstrate a significantly greater reduction in a pre-specified secondary analysis of patients who completed four weeks of treatment with each of the products. It was also noted that the reduction in serum phosphorus was greater with lanthanum after the initial week of treatment ($p=0.024$).

sucroferric oxyhydroxide (Velphoro) and sevelamer hydrochloride (Renagel)

A randomized clinical trial was performed to determine the ability of sucroferric oxyhydroxide in lowering serum phosphorus in patients with ESRD on dialysis.¹²³ In the first study, 154 patients with ESRD on hemodialysis having elevated levels of serum phosphorus (greater than 5.5 mg/dL but less than 7.75 mg/dL) were randomized to receive sucroferric oxyhydroxide at 250 mg; 1,000 mg; 1,500 mg; 2,000 mg; or 2,500 mg daily or active-control (sevelamer HCL) after a two-week phosphate binder washout period. Sucroferric oxyhydroxide treatment was divided across meals and no dose titration was allowed. At the end of the study, serum phosphorus levels were compared to baseline values and it was found that sucroferric oxyhydroxide was efficacious ($p \leq 0.016$) for all doses, with the exception of the 250 mg daily dose. Sucroferric oxyhydroxide also had similar GI adverse event profiles compared to sevelamer HCL and no dose-dependent GI trend events were observed.

sucroferric oxyhydroxide (Velphoro) and sevelamer carbonate (Renvela)

In a clinical study, 1,054 patients with elevated serum phosphorus levels (greater than or equal to 6 mg/dL), following a two- to four-week phosphate binder washout phase and on hemodialysis ($n=968$) or peritoneal dialysis ($n=87$), were randomized to receive 1,000 mg daily of sucroferric oxyhydroxide ($n=707$) or active control (sevelamer carbonate, $n=348$) for 24 weeks.¹²⁴ At the end of 24 weeks, patients on hemodialysis ($n=93$) whose serum phosphorus levels were controlled (less than 5.5 mg/dL) with sucroferric oxyhydroxide were re-randomized to receive a maintenance dose of sucroferric oxyhydroxide ($n=44$) or a non-effective dose (250 mg daily, $n=49$) for an additional three weeks. At the end of week 27, the study showed that sucroferric oxyhydroxide (1,000 to 3,000 mg daily) was statistically significantly superior ($p < 0.001$) in maintaining a mean lower serum phosphorus level compared to the low dose control, 5 mg/dL versus 6.8 mg/dL, respectively. Following the completion of the study, 658 patients were treated in the 28-week extension study with sucroferric oxyhydroxide ($n=391$) or sevelamer carbonate ($n=267$) according to the patient's original randomization. The patients' serum phosphorus levels declined during the first few weeks and then remained consistent through 12 months of treatment. Serum iron level increases from baseline were not clinically significant, did not differ significantly from the active control, and did not accumulate during the year of treatment. Similarly, there were no clinically significant changes in vitamins A, D, E, and K when using sucroferric oxyhydroxide.

ferric citrate (Auryxia) and placebo

In a four-week double-blind, parallel-group study, 192 subjects with CKD, on dialysis and with serum phosphorus between 6.1 and 10 mg/dL, were randomized to ferric citrate 1.5 g, 3 g, or 6 g per day or placebo.¹²⁵ The mean change in serum phosphorus reported for placebo, ferric citrate 1.5 g, 3 g, and 6g groups were 0.04, -1.3, -2.2, and -4.1 mg/dL, respectively. Serum phosphorus levels of ≤ 5.5 mg/dL were reached for 2.5, 16.7, 50, and 92.6 percent of patients in each group, respectively. Common adverse events reported were gastrointestinal in nature.

ferric citrate (Auryxia) and calcium acetate and/or sevelamer carbonate (Renvela)

In a long-term, active-control trial, a total of 441 patients with CKD and a serum phosphorus of 7.5 mg/dL during a two-week washout period were randomized in a 2:1 manner to ferric citrate or an active control, calcium acetate, and/or sevelamer carbonate.¹²⁶ Ninety-six percent of patients were on hemodialysis. After randomization, patients either continued the active control drug at the same dose, or started ferric citrate six tablets per day, divided with meals. The phosphate binder dose was adjusted to maintain a serum phosphorus level between 3.5 and 5.5 mg/dL, to a maximum of 12 tablets per day. Similar decreases in serum phosphorus were seen in both groups by week 12 and remained through week 52. Following week 52, patients who received ferric citrate were eligible to enter a four week placebo-controlled withdrawal phase. Patients were randomized 1:1 to ferric citrate or placebo. Serum phosphorus level continued to decrease in the ferric citrate group by 0.24 mg/dL and increased by 1.8 mg/dL in the placebo group ($p < 0.0001$).

META-ANALYSIS

A systematic review evaluated the effect of calcium-based (calcium carbonate or calcium acetate) versus non-calcium-based phosphate binders (sevelamer hydrochloride, sevelamer carbonate, or lanthanum) on mortality in patients with chronic kidney disease.¹²⁷ Randomized and non-randomized trials from August 2008 through October 2012 were retrieved from numerous databases, examined, and combined with a previous meta-analysis for assessment of outcomes. The primary outcome assessed was all-cause mortality and the secondary outcomes assessed were cardiovascular events (fatal and non-fatal stroke; fatal and non-fatal myocardial infarction; and sudden death), vascular calcification, vascular compliance, and fractures. Eight new studies (four open-label randomized controlled trials, two observational cohort studies; one blinded randomized controlled trial; and one cross-sectional study) were added to the ten studies from a previous meta-analysis and included 3,230 participants (1,726 received calcium carbonate or calcium acetate; 774 received sevelamer; and 730 received lanthanum). Eleven randomized studies ($n=4,622$) were used to assess all-cause mortality and showed a 22 percent reduction in all-cause mortality in patients receiving non-calcium based phosphate binders compared to those taking calcium-based therapy (risk ratio 0.78, 95% CI 0.61-0.98). Furthermore, follow-up at 24 months indicated a significant reduction in mortality in patients taking non-calcium based phosphate binders compared to patients taking calcium-based phosphate binders. Patients taking calcium-based phosphate binders had increased coronary artery calcification compared to patients taking non-calcium based phosphate binders. A subgroup analysis to determine whether mortality varied by type of non-calcium based phosphate binder showed a statistically non-significant decrease in mortality in patients taking either sevelamer or lanthanum compared to patients taking calcium-based phosphate binders. Limitations of the review include the fact that no new studies examined cardiovascular mortality so the review cannot distinguish between CV mortality and other types of mortality on the basis of type of phosphate binder used. Sucroferric oxyhydroxide was not available at the time of this meta-analysis.

SUMMARY

Chronic kidney disease is a prevalent disease state in the United States impacting over 26 million Americans. As kidney function deteriorates, the levels of phosphorus increase which results in hyperphosphatemia. Hyperphosphatemia can lead to severe complications, such as renal bone disease and soft tissue calcification, including cardiac and vasculature tissue calcification, and increase the risk of death. Studies have shown that control of hyperphosphatemia through dietary phosphorus management, dialysis, and phosphate binders is critical in the prevention and delay of renal osteodystrophy and soft tissue calcifications. The NKF-K/DOQI and KDIGO guidelines do not strongly prefer one type of phosphate binder over another for adults and have noted that the selection of an appropriate phosphate binder should be individualized and based on various clinical parameters, not phosphorus lowering alone.

Phosphate-binding therapy with calcium acetate (PhosLo, Eliphos, and Phoslyra) is as effective as sevelamer (Renagel, Renvela) in reducing serum phosphate levels. Sucroferric oxyhydroxide (Velphoro) has also shown phosphate lowering capabilities when compared to sevelamer HCl and sevelamer carbonate without causing a clinically significant iron accumulation. Ferric citrate (Auryxia) was also shown to similarly decrease serum phosphorus levels compared to calcium acetate and/or sevelamer carbonate (Renvela). Sevelamer hydrochloride (Renagel) and sevelamer carbonate (Renvela) have been compared in one trial which demonstrated similar efficacy. However, increased serum bicarbonate levels were observed in the serum carbonate (Renvela) group compared to the sevelamer hydrochloride group (Renagel).

Unlike other agents, hypercalcemia occurs more frequently with calcium acetate (PhosLo, Eliphos, and Phoslyra) in a small portion of patients. However, calcium supplementation may be required with sevelamer (Renagel, Renvela) to enhance control of secondary hyperparathyroidism.

Lanthanum (Fosrenol) is another non-calcium, non-aluminum, phosphate-binding agent. The long-term effects of lanthanum (Fosrenol) on bone remain unclear.

In conclusion, all phosphate binders are efficacious in reducing serum phosphate levels; one product has not been found to be superior over another and therapy should be individualized to meet the patient's unique medical needs.

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