

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

IgA Nephropathy Agents

Filspari™, Tarpeyo™, Vanrafia®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Tarpeyo™ (budesonide), Filspari™ (sparsentan), Vanrafia® (atrasentan),
Please note that Fabhalta™ will not be considered until confirmatory trials show estimated glomerular filtration (eGFR) rate results.

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Has the diagnosis of IgA nephropathy been confirmed by biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request from a nephrologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member used the maximally tolerated FDA-approved dose of an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) for at least 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member used the maximally tolerated FDA-approved dose of a sodium-glucose cotransporter 2 (SGLT2) for at least 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the provider ruled out any secondary causes of IgAN (e.g. hepatitis, HIV, liver cirrhosis, IgA vasculitis)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the member received optimal blood pressure management for at least 90 days (defined as 140/90 mmHg or lower on all clinically appropriate medications)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Please provide documentation
7. Does the member have a high risk of disease progression with either proteinuria with greater than 1.0 grams protein per day OR a urine protein-to-creatinine ratios of 1.5 g/g or higher?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

Tarpeyo™:			
1. Has the member tried and failed at least one systemic glucocorticoid?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does member have an eGFR of 35 mL/min/1.73 m ² or higher?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
Filspari™:			
1. Will all ACE inhibitors, ARBs, endothelial receptor antagonists (ERAs) and/or aliskerin be discontinued prior to initiation of Filspari?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does member have an eGFR of 30 mL/min/1.73 m ² or higher?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is there current documentation of ALL of the following? a. Liver aminotransferase and total bilirubin levels b. For women of childbearing potential: a negative pregnancy test	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the prescribing provider enrolled in the Filspari™ REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
Vanrafia™			
1. Does member have an eGFR of 30 mL/min/1.73 m ² or higher?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. For women of childbearing potential, is there a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
Fabhalta® (IF confirmatory trials show a slowing of kidney function decline)			
1. Does member have an eGFR of 30 mL/min/1.73 m ² or higher?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Have Tarpeyo™, Filspari™, and Vanrafia® all been trialed and failed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Is the prescribing provider enrolled in the Fabhalta® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Does clinical documentation show positive clinical response with either reduction in urine protein-to-creatinine ratio or reduction in proteinuria?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member remained compliant with optimal blood pressure management?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. For Tarpeyo™: Reauthorization will not be covered. Limited to a 9-month treatment period per package insert.	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. For Filspari™ and Vanrafia®: Does clinical documentation show ALT and AST measurements every 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. For Filspari™ and Vanrafia®: For women of childbearing potential, is ongoing pregnancy testing during and following treatment documented?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:

Physician Signature:

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Policy: PHARM-CHIP-167

Origination Date: 04/28/2025

Reviewed/Revised Date: 09/10/2025

Next Review Date: 09/10/2026

Current Effective Date: 10/01/2025

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