AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Voyxact® (sibeprenlimab-szsi)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: 400 mg/2 mL injected subcutaneously once every 4 weeks

Quantity Limit: 2 mL (1 injection = 400 mg) per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 9 months

- ❑ Member is 18 years of age or older
- ❑ Provider is a nephrologist
- ❑ Member has a diagnosis of biopsy-proven, primary immunoglobulin A nephropathy (IgAN) and is at risk of rapid disease progression
- ❑ Member is currently established on a stable and maximally tolerated dose of a renin-angiotensin-aldosterone system (RAAS) inhibitor (angiotensin converting enzyme [ACE] inhibitor or angiotensin receptor blocker [ARB]), for at least 90 days **(verified by chart notes and/or pharmacy paid claims)**

(Continued on next page)

- ❑ Member's lab test results taken within the last 30 days must be submitted to document **ALL** the following:
  - ❑ Total urine protein ≥ 1 g/day **OR** urine protein-to-creatinine ratio is ≥ 0.75 g/g
  - ❑ eGFR ≥ 30 mL/min/1.73 m^2
- ❑ Member is **NOT** currently receiving dialysis and has **NOT** undergone a kidney transplant
- ❑ Member has had unsuccessful 3-month trials of Vanrafia™ or Filspari® **AND** Tarpeyo® **(must submit chart notes or lab test results confirming therapy failure)**
- ❑ Member is **NOT** using concomitant therapy with any of the following: Voyxact®, Vanrafia™, Tarpeyo®, Filspari®, Fabhalta® or other complement inhibitor therapies (e.g., Empaveli®, Soliris®, Ultomiris® or Voydeya™)

Reauthorization: 12 months. All criteria that apply must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Member must have reduction in urine protein-to-creatinine ratio (UPCR) or proteinuria from baseline after initial approval, and reduction or stabilization in UPCR or proteinuria after subsequent approvals **(current lab test results must be submitted for documentation)**
- ❑ Member's lab test results taken within the last 30 days must be submitted to document eGFR ≥ 30 mL/min/1.73 m^2
- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., hepatotoxicity, acute kidney injury)

Medication being provided by Specialty Pharmacy – Proprium Rx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 1/22/2026
REVISED/UPDATED/REFORMATTED: 2/18/2026;