SENTARA HEALTH PLANS

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 1-800-750-9692**. 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: Vanrafia™ (atrasentan)

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

Member Name: _____

Member Sentara #: _____ **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: Oral: 0.75 mg once daily with or without food

Quantity Limit: 1 tablet per day

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

(Continued on next page)

- ❑ Member is currently established on a stable and maximally tolerated dose of a renin-angiotensin system (RAS) 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)**
- ❑ 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
  - ❑ Urine protein-to-creatinine ratio is ≥ 1.5 g/g
  - ❑ eGFR ≥ 30 mL/min/1.73 m^2
- ❑ Member does **NOT** have severe hepatic impairment, and periodic liver test monitoring will be performed for members with ALT or AST > 3 times the upper limit of normal (ULN) at baseline
- ❑ Member is **NOT** currently receiving dialysis and has not undergone a kidney transplant
- ❑ For females of reproductive potential, a negative pregnancy test is required prior to treatment initiation of Vanrafia™ (atrasentan) **(provider must attest)**
- ❑ Member must meet **ONE** of the following:
  - ❑ Member has had an unsuccessful 3-month trial of oral generic budesonide EC capsules **(must submit chart notes or lab test results confirming therapy failure)**
  - ❑ Member has an intolerance or hypersensitivity to oral generic budesonide EC capsules or an FDA labeled contraindication to oral generic budesonide EC capsules that is not expected to occur with the requested agent **(documentation of intolerance or hypersensitivity must be submitted)**
- ❑ Member is **NOT** using concomitant therapy with any of the following: 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 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: 5/22/2025
REVISED/UPDATED/REFORMATTED: 6/9/2025