SENTARA COMMUNITY PLAN
(MEDICAID)

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Filspari™ (sparsentan)

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

Recommended Dosage: Oral: Initial: 200 mg once daily for 14 days. On day 15, increase to 400 mg once daily (recommended dose), if tolerated

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: 6 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

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- ❑ Member has been on a stable, maximized dose of a renin-angiotensin system (RAS) inhibitor (≥ 50% of maximum labeled dose), including either an angiotensin-converting enzyme (ACE) inhibitor or ARB, for at least 90 days **(verified 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/1.73m^2
- ❑ Member does **NOT** have ALT or AST > 3 times the upper limit of normal (ULN), and provider will measure aminotransferase levels and total bilirubin monthly for the first 12 months after initiation, then every 3 months for the duration of treatment
- ❑ Requested medication will be discontinued permanently if ALT and/or AST levels rise to > 8 times the ULN if no other cause is found
- ❑ A negative pregnancy test is required prior to treatment initiation, monthly during treatment, and 1 month after the last dose of Filspari™
- ❑ Member will avoid concomitant therapy with major interacting drugs, including **ALL** the following:
  - ❑ Renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists (ERAs), and aliskiren
  - ❑ Strong CYP3A inhibitors
  - ❑ Strong CYP3A inducers
  - ❑ Histamine H2 receptor antagonists
  - ❑ Proton pump inhibitors
  - ❑ Sensitive substrates of P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP)
- ❑ Member's renal function and potassium levels will be monitored frequently, especially for members with advanced kidney disease, those taking concomitant potassium-increasing drugs (e.g., potassium supplements, potassium-sparing diuretics), and those using potassium-containing salt substitutes
- ❑ Member is **NOT** using concomitant therapy with Tarpeyo® (budesonide delayed-release)

Reauthorization: 12 months. 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.

- ❑ Member continues to meet all initial authorization criteria
- ❑ Member must have reduction in proteinuria from baseline after initial approval, and reduction or stabilization in proteinuria after subsequent approvals **(current lab test results must be submitted for documentation)**

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- ❑ Member has **NOT** experienced any treatment-restricting adverse effects (e.g., hepatotoxicity, acute kidney injury, severe hypotension, hyperkalemia)

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****