HIGHMARK WHOLECARE

Updated: 07/2025
PARP Approved: 07/2025

Prior Authorization Criteria

Vanrafia (atrasentan)

All requests for Vanrafia (atrasentan) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of **primary immunoglobulin A nephropathy (IgAN)** and the following criteria is met:

- Must be prescribed by or in consultation with a nephrologist
- Diagnosis has been confirmed by biopsy
- Must have an estimated glomerular filtration rate ≥ 30 ml/min/1.73m^2
- Must have a total urine protein ≥ 1.0 g/day
- Must be at risk of rapid disease progression defined as having a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g
- Must have tried maximum tolerated dose of a renin-angiotensin system (RAS) inhibitor treatment [i.e. angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB)] for at least 3 months or had an intolerance or contraindication to RAS inhibitor treatment.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Decrease from baseline in total urine protein or UPCR
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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VANRAFIA (ATRASENTAN)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

Has the diagnosis been confirmed by biopsy? ☐ Yes ☐ No

What is the estimated glomerular filtration rate? _____
What is the total urine protein? _____
What is the urine protein-to-creatinine ration (UPCR)? _____

Is the member currently stable on renin-angiotensin system (RAS) inhibitor treatment (ie. ACE or ARB) ☐ Yes, please list below ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

Which of the following have improved and what is the current level?
- ☐ Total urine protein _____
- ☐ Urine protein-to-creatinine ration (UPCR)? _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date