Updated: 03/2023
DMMA Approved: 05/2023

Request for Prior Authorization for Filspari (sparsentan)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Filspari (sparsentan) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Prior Authorization Criteria:

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/1.73m2
- 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)] 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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FILSPARI (SPARSENTAN) 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 Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8:00 am to 7:00 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
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:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

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