USFHP Prior Authorization Request Form for
sparsentan (Filspari), atrasentan (Vanrafia)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Prior authorization expires after 9 months. Renewal PA criteria does not expire. Clinical documentation may be required.

Step 1

Please complete patient and physician information (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2

Please complete clinical assessment:

1. What medication is being requested?	☐ Filspari Proceed to question **2**	☐ Vanrafia Proceed to question **4**
2. Does the provider acknowledge that the requested medication is only available through a REMS program due to the risk of hepatotoxicity and embryo-fetal toxicity, and will the provider follow the monitoring requirements for hepatic function?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Will the patient be receiving renin-angiotensin-aldosterone system inhibitors (for example ACE-inhibitors or ARBs such as irbesartan, telmisartan, losartan; or spironolactone), endothelin receptors antagonists (for example ambrisentan or bosentan) or aliskiren along with the requested medication?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Does the patient have an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73m^2?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.*	☐ Yes Proceed to question **6**	☐ No Skip to question **8**
6. Has there been a reduction in urine protein-to-creatinine ratio (UPCR) from baseline?	☐ Yes **Sign and date below**	☐ No Proceed to question **7**
7. Has there been a reduction in proteinuria from baseline?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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8. Is the patient 18 years of age or older?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the drug prescribed by a nephrologist?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the indication or diagnosis?	☐ Biopsy-verified primary immunoglobulin A nephropathy (IgAN) – **proceed to question 11** ☐ IgAN due to systemic lupus erythematosus – **STOP: Coverage not approved.** ☐ IgAN due to liver cirrhosis – **STOP: Coverage not approved.** ☐ IgAN due to Henoch-Schonlein purpura – **STOP: Coverage not approved.** ☐ IgAN due to pulmonary arterial hypertension – **STOP: Coverage not approved.** ☐ IgAN due to focal segmental glomerulosclerosis (FSGS) – **STOP: Coverage not approved.** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
11. Is there cellular crescents in more than 25% of sampled glomeruli?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the patient have a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.0 g/g?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient currently receiving dialysis or has the patient ever undergone a kidney transplant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Has the patient received immunosuppressants, including corticosteroids, within the past 2 weeks OR is expected to need immunosuppressants in the next 6 months?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Has the patient continued to have proteinuria despite maximal ACE-inhibitor or ARB therapy and is at high risk for disease progression?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**

16. Are the patient's baseline liver aminotransferase (AST and ALT) levels elevated to above three times the upper limit of normal?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**
17. What is the patient's sex?	☐ Female Proceed to question **18**	☐ Male **Sign and date below**
18. Is the patient of childbearing potential?	☐ Yes Proceed to question **19**	☐ No **Sign and date below**
19. Does the patient agree to use effective contraception before starting treatment, during treatment and for at least 1 month after cessation of therapy?	☐ Yes Proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **21**
21. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin)?	☐ Yes Proceed to question **22**	☐ No **STOP** **Coverage not approved**
22. Will the patient be tested for pregnancy before, during and 1 month after treatment discontinuation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____