



4/2/2026
Prior Authorization
Internal Use Only
JOHNS HOPKINS HEALTH PLANS Filspari - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at <b>1-410-424-4607</b> . Please contact Johns Hopkins Health Plans at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Filspari - Priority Partners MCO.

Drug Name (select from list of drugs shown) Filspari (sparsentan)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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<b>Please circle the appropriate answer for each question.</b>	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met to be eligible for benefit coverage.	
[If yes, skip to question 9.]	
2. Does the patient have a documented diagnosis of primary immunoglobulin A nephropathy (IgAN) with confirmation via biopsy results?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Does the patient have a documented estimated Glomerular Filtration Rate (eGFR) greater than or equal to 30 mL/min/1.73m <sup>2</sup> ?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Does the patient have documented baseline laboratory results that show at least one of the following: A) Total urine protein greater than or equal to 1.0 g/day, B) Urine protein-to-creatinine ration (UPCR) greater than or equal to 1.5 g/g?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Has the patient had a documented trial (at least 3 months) and inadequate response, or contraindication, to an optimally dosed regimen containing an angiotensin-converting enzyme inhibitor (ACEi) or an angiotensin II receptor blocker (ARB)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Has the patient had a documented trial and inadequate response, or contraindication, to systemic oral glucocorticoids (i.e., prednisone, methylprednisolone)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
7. Does the patient have any of the following exclusions to therapy: A) Pregnancy, B) Concurrent use with ACEis, ARBs, endothelin receptor antagonists (ERAs), or aliskiren, C) Concurrent use with Tarpeyo, Vanrafia, or Fabhalta, D) Any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
8. Is the patient 18 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
9. Has the patient had a documented beneficial response to treatment, evidenced by one of the following: A) Reduction	<input type="checkbox"/> Y <input type="checkbox"/> N

in total urine protein from baseline, B) Reduction in UPCR from baseline? _____	
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
10. Does the patient have a documented estimated Glomerular Filtration Rate (eGFR) greater than or equal to 30 mL/min/1.73m <sup>2</sup> ? _____	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Does the patient have any of the following exclusions to therapy: A) Pregnancy, B) Concurrent use with ACEis, ARBs, endothelin receptor antagonists (ERAs), or aliskiren, C) Concurrent use with Tarpeyo, Vanrafia, or Fabhalta, D) Any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported? _____	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>