PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

4/2/2026

Prior Authorization

Internal Use Only

JOHNS HOPKINS HEALTH PLANS

Vanrafia - 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 **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Vanrafia - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Vanrafia Tablets (atrasentan)

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: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y 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 10.]		
2.	Does the patient have a documented diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed by renal biopsy?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
3.	Does the patient have an estimated Glomerular Filtration Rate (eGFR) greater than or equal to 30 mL/min/1.73m2?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
4.	Does the patient have baseline laboratory results that show at least one of the following: A) Total urine protein greater than or equal to 1.0 g/day, OR B) Urine protein-to-creatinine ration (UPCR) greater than or equal to 1.5 g/g?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Has the patient received the maximum or maximally tolerated dose of an angiotensin-converting enzyme inhibitor (ACEi) or an angiotensin II receptor blocker (ARB) for at least 3 months, and will continue this therapy, unless their use is contraindicated?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Has the patient had a 3-month trial and inadequate response to sodium-glucose cotransporter 2 (SGLT2) inhibitor therapy, unless contraindicated?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 8.]		
7.	Has the patient had trial and inadequate response, or contraindication, to systemic oral glucocorticoids (i.e., prednisone, methylprednisolone)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
8.	Does the patient have any of the following exclusions to therapy: A) Pregnancy, B) A history of a hypersensitivity reaction to atrasentan or any component of the requested medication, C) Concurrent use with endothelin receptor antagonists (ERAs), D) Concurrent use with Tarpeyo, Fabhalta, or Filspari, E) Any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N	
	[If yes, no further questions.]		
9.	Is the patient 18 years of age or older?	Y N	

[No further questions.]	
10. Has the patient had a documented beneficial response to treatment, evidenced by one of the following: A) Reduction in total urine protein from baseline, OR B) Reduction in UPCR from baseline?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
11. Does the patient have a documented estimated Glomerular Filtration Rate (eGFR) greater than or equal to 30 mL/min/1.73m2?	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Does the patient have any of the following exclusions to therapy: A) Pregnancy, B) A history of a hypersensitivity reaction to atrasentan or any component of the requested medication, C) Concurrent use with endothelin receptor antagonists (ERAs), D) Concurrent use with Tarpeyo, Vanrafia, or Fabhalta, E) Any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	Y N

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.

Prescriber (Or Authorized) Signature and Date