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

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 9 months. Renewal PA criteria does not expire.

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 1.5 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**

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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

[02 May 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: