TRICARE Prior Authorization Request Form for
sibeprenlimab-szsi (Voyxact)

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 in 9 months. Initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely.

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 the clinical assessment:**

1. 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 (subject to verification) Proceed to question **9**	☐ No Proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication being prescribed by a nephrologist?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a biopsy verified primary immunoglobulin A nephropathy (IgAN) without cellular crescents in more than 25% of sampled glomeruli?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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 **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have urinary protein excretion GREATER THAN OR EQUAL TO 1.0 g/day OR urine protein-to-creatinine ratio (UPCR) GREATER THAN OR EQUAL TO 0.75?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Does the patient continue to have proteinuria despite maximal Angiotensin-Converting Enzyme (ACE) inhibitor OR Angiotensin II receptor blockers (ARB) therapy AND an SGLT-2 inhibitor (for example, empagliflozin, dapagliflozin) AND is at high risk for disease progression?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the patient use Voyxact concomitantly with Filspari or Vanrafia or Fabhalta?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
9. Has the patient experienced a reduction in urine protein-to-creatinine ratio (UPCR) from baseline or reduction in proteinuria from baseline?	☐ 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

[03 February 2026]

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