Filspari (sparsentan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTER (if different than prescriber):	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ **YES** (if yes, complete below) ☐ **NO**		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Focal Segmental Glomerulosclerosis(FSGS) ☐ Other diagnosis: _____ ICD-10 Code(s):	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will the patient be using the drug as a part of the clinical trial? ☐ **Yes** ☐ **No**

Is Filspari (sparsentan) being prescribed by, or in consultation with, a nephrologist? ☐ **Yes** ☐ **No**

Will Filspari (sparsentan) be used in combination with Tarpeyo (budesonide), Voyxact (sibeprenlimab), Fabhalta (iptacopan), or Vanrafia (atrasentan)? ☐ **Yes** ☐ **No**

Will Filspari(sparsentan) be used in combination with Soliris(eculizumab) or Ultomiris(ravulizumab), Empaveli(pegcetacoplan) or Voydeya(danicopan)? ☐ **Yes** ☐ **No**

Does the patient have an estimated eGFR of at least 30 mL/min/1.73 m2? ☐ **Yes** ☐ **No** ***Please provide documentation.***

Has the patient been on a maximum tolerate dose of an angiotensin converting enzyme (ACE) inhibitor or a Angiotensin II receptor blocker? ☐ **Yes** ☐ **No** ***Please provide documentation.***

If no to the question above, does the patient have an absolute contraindication to angiotensin converting enzyme (ACE) inhibitor or a Angiotensin II receptor blocker? ☐ **Yes** ☐ **No** ***Please provide documentation.***

<u>For diagnosis of FSGS, please also answer the following</u>:
Does patient have a diagnosis of focal segmental glomerulosclerosis(FSGS)? ☐ **Yes** ☐ **No**
Please submit documentation such as kidney biopsy or genetic testing or documentation of a genetic mutation in a podocyte protein associated with FSGS.

Does patient have FSGS secondary to another condition? ☐ **Yes** ☐ **No** ***Please provide documentation.***

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Does patient have nephrotic syndrome? ☐ **Yes** ☐ **No** ***Please provide documentation.***

Does patient have a urine protein/creatinine(UP/C) greater than or equal to 1.5g/g (170mg/mmol)? ☐ **Yes** ☐ **No** ***Please provide documentation.***

Will Filspari (sparsentan) be used in combination with Tarpeyo (budesonide), Voyxact (sibeprenlimab), Fabhalta (iptacopan), or Vanrafia (atrasentan)? ☐ **Yes** ☐ **No**

Will Filspari(sparsentan) be used in combination with Soliris(eculizumab) or Ultomiris(ravulizumab), Empaveli(pegcetacoplan) or Voydeya(danicopan)? ☐ **Yes** ☐ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

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