Vanrafia (atrasentan)
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:**
☐ Primary immunoglobulin A nephropathy (IgAN) ☐ Other diagnosis: _____ ICD-10 Code(s):	

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

Is patient going to be using drug in combination with a clinical trial? ☐ **Yes** ☐ **No**

Is the prescriber a nephrologist or urologist? ☐ **Yes** ☐ **No**

Initial Request:
For a diagnosis of primary IgAN:
Was the patient's diagnosis confirmed by renal biopsy? ☐ **Yes** ☐ **No** ***Please submit documentation.***

Does the patient have proteinuria greater than or equal to 1 g/day? ☐ **Yes** ☐ **No** ***Please submit documentation.***

Does the patient have an estimated eGFR of greater than or equal to 30 mL/min/1.73 m_2?
☐ **Yes** ☐ **No** ***Please submit documentation.***

Is the patient on a maximally tolerated dose of an angiotensin converting enzyme (ACE) inhibitor or and angiotensin II receptor blocker (ARB)? ☐ **Yes** ☐ **No** ***Please provide documentation.***

Will the patient continue the use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs) in combination with Vanrafia (atrasentan)? ☐ **Yes** ☐ **No**

Does the patient have an absolute contraindication to ACE inhibitors and ARBs? ☐ **Yes** ☐ **No** ***Please submit documentation.***

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

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Does the patient have chronic kidney disease from another cause? ☐ **Yes** ☐ **No**

Does the patient have rapidly progressive glomerulonephritis (RPGN), IgA vasculitis, or nephrotic syndrome? ☐ **Yes** ☐ **No**

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

Is the patient continuing to have a positive clinical response? ☐ **Yes** ☐ **No** ***Please submit documentation.***

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:** _____

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