# 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): | | | |

*Continued on next page*

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company

# 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:** _____

| **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)<br>☐ 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**

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company

# 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:** _____

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

**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**

**Will Vanrafia (atrasentan) be used in combination with Soliris(eculizumab) or Ultomiris(ravulizumab), Empaveli(pegcetacoplan) or Voydeya(danicopan)?** ☐ **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:** _____

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company

# 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:** _____

**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

©2017-2024 Prime Therapeutics Management LLC, a Prime Therapeutics company