UnitedHealthcare Pharmacy
Clinical Pharmacy Program

Program Number	2025 P 1479-1
Program	Prior Authorization/Notification
Medication	Filspari™ (sparsentan), Vanrafia™ (atrasentan)
P&T Approval Date	6/2025
Effective Date	9/1/2025

1. Background:

Filspari (sparsentan) is indicated to slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression. Vanrafia (atrasentan) is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g.

Vanrafia is approved under accelerated approval based on a reduction of proteinuria. It has not been established whether Vanrafia slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

2. Coverage Criteria[a]:

I. Initial Authorization

A. **Filspari** will be approved based upon **all** of the following criteria:

1. Diagnosis of primary immunoglobulin A nephropathy (IgAN)

-AND-

2. Patient is at risk of disease progression

-AND-

3. Used to slow kidney function decline

Authorization will be issued for 12 months

B. **Vanrafia** will be approved based upon **all** of the following criteria:

1. Diagnosis of primary immunoglobulin A nephropathy (IgAN)

-AND-

2. Patient is at risk of disease progression

-AND-

3. Used to reduce proteinuria

Authorization will be issued for 12 months

II. Reauthorization

1. **Filspari or Vanrafia** will be approved based on the following criterion:

   a. Documentation of positive clinical response

Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Medical Necessity and Supply limits may be in place.

4. References:

1. Filspari [package insert]. San Diego, CA: Traverse Therapeutics, Inc; April 2025.
2. Vanrafia [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2025.
3. KDIGO 2021 Glomerular Diseases Guideline. October 2021; 100 (4S).

Program	Prior Authorization/Notification – Filspari, Vanrafia
Change Control	
6/2025	New program