AETNA BETTER HEALTH®
Coverage Policy/Guideline

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| Name: | Filspari | Page: | 1 of 3 |
| Effective Date: | 5/23/2025 | Last Review Date: | 4/2025 |

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| Applies to: | ☒Illinois<br>☒Maryland<br>☐Michigan | ☐Florida<br>☒Florida Kids<br>☒Virginia | ☒New Jersey<br>☒Pennsylvania Kids |

## Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Filspari under the patient's prescription drug benefit.

## Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

FDA-approved Indications[1]

Filspari is indicated to slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression.

All other indications are considered experimental/investigational and not medically necessary.

## Applicable Drug List:

Filspari

## Policy/Guideline:

**Documentation**

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests:

- Kidney biopsy confirming a diagnosis of primary immunoglobulin A nephropathy (IgAN).
- Laboratory report and/or chart note(s) indicating the member has proteinuria greater than or equal to 1 gram per day (g/day) or baseline urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 grams per gram (g/g).

Continuation requests:

- Laboratory report and/or chart note(s) indicating the member has decreased levels of proteinuria or UPCR from baseline.

## Coverage Criteria

Primary Immunoglobulin A Nephropathy (IgAN)[1-3]

Authorization of 12 months may be granted when all of the following criteria are met:

- Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy.
- Member has either of the following:
  - Proteinuria greater than or equal to 1 g/day;
  - UPCR greater than or equal to 0.8 g/g
- Member has received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or angiotensin II receptor blocker [ARB]) for at least 3 months prior to initiation of therapy, or member has an intolerance or contraindication to RAS inhibitors

## Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in all members (including new members) who are currently receiving the requested medication and who are experiencing benefit from therapy as evidenced by either of the following:

- Decreased levels of proteinuria from baseline.
- Decrease in UPCR from baseline.

## Approval Duration and Quantity Restrictions:

**Initial Approval:** 10 months

**Renewal Approval:** 12 months

**Quantity Level Limit:** Reference Formulary for drug specific quantity level limits

## References:

1. Filspari [package insert]. San Diego: Travere Therapeutics, Inc.; September 2024.
2. ClinicalTrial.gov. National Library of Medicine (US). Identifier NCT03762850 A Study of the Effect and Safety of Sparsentan in the Treatment of Patients With IgA Nephropathy (PROTECT). September 6, 2023. Available from: https://clinicaltrials.gov/ct2/show/study/NCT03762850.

3. Kidney Disease: Improving Global Outcomes (KDIGO) Glomerular Diseases Work Group. KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases. *Kidney Int*. 2021 Oct; 100 (4S): S1-S276. doi: 10.1016/j.kint.2021.05.021.