AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Tarpeyo	Page:	1 of 2
Effective Date:	9/16/2026	Last Review Date:	8/2026
Applies to:	☒Illinois ☒New Jersey ☒Pennsylvania Kids	☐Florida ☒Maryland ☐Virginia	☒Florida Kids ☐Michigan ☐Kentucky PRMD

Intent:

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

Description:

FDA-Approved Indication[1]

Tarpeyo is indicated to reduce the loss of kidney function 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:

Tarpeyo

Policy/Guideline:

Documentation

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

- Kidney biopsy confirming a diagnosis of primary immunoglobulin A nephropathy (IgAN).
- Laboratory report and/or chart note(s) of baseline proteinuria or baseline urine protein-to-creatinine ratio (UPCR) obtained within 3 months prior to initiation of the requested drug.

Prescriber Specialties

This medication must be prescribed by or in consultation with a nephrologist.

Coverage Criteria

Primary Immunoglobulin A Nephropathy (IgAN)[1-4]

Authorization of up to 10 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 obtained within 3 months prior to initiation of the requested drug:

  - Proteinuria greater than or equal to 0.5 g/day
  - UPCR greater than or equal to 0.5 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]) or member has an intolerance or contraindication to RAS inhibitors.
- Member is receiving concomitant therapy with other therapies used to treat IgAN (e.g., ACEI, ARB, Filspari).

Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must meet all requirements in the coverage criteria section.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 10 months

Quantity Limit: 120 tablets per 30 days

References:

1. Tarpeyo [package insert]. Stockholm, Sweden: Calliditas Therapeutics AB; June 2024.
2. Fellstrom BC, Baratt J, Cook H, et al. Targeted-release budesonide versus placebo in patients with IgA nephropathy (NEFIGAN): a double-blind, randomized, placebo-controlled phase 2b trial. Lancet. 2017 May 27;389 (10084): 2117-2127.
3. Kidney Disease: Improving Global Outcomes (KDIGO). KDIGO 2025 Clinical Practice Guideline for the Management of Immunoglobulin A Nephropathy (IgAN) and Immunoglobulin A Vasculitis (IgAV). Kidney Int. 2025 Oct; 108 (4S): S1-S71.
4. Barratt J, Lafayette R, Kristensen J, et al. Results from part A of the multi-center, double-blind, randomized, placebo-controlled NefIgArd trial, which evaluated targeted-release formulation of budesonide for the treatment of primary immunoglobulin A nephropathy [published online ahead of print, 2022 Oct 19]. Kidney Int. 2022;S0085-2538(22)00836-5. doi:10.1016/j.kint.2022.09.017.