BlueCross BlueShield Federal Employee Program.

FILSPARI
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Filspari tablets

(sparsentan)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 400 milligrams per day? ❑Yes* ❑No

If YES, please specify the requested milligrams per day: _____ mg per day

1. Does the patient have a diagnosis of primary immunoglobulin A nephropathy (IgAN)? ❑Yes ❑No
2. Will Filspari be used in combination with angiotensin receptor blockers (ARBs), endothelin receptor antagonists (ERAs), or aliskiren? ❑Yes* ❑No

   If YES, please specify the medication(s): _____
3. Has the patient been on Filspari continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the prescriber agree to monitor the patient's AST, ALT, and total bilirubin before initiating treatment and monthly for the first 12 months? ❑Yes ❑No

b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

If YES, does the prescriber agree not to initiate treatment until after confirmation of a negative pregnancy test? ❑Yes* ❑No

If YES, will the patient be advised to use effective contraception before the initiation of treatment, during treatment, and for one month after the last dose of Filspari? ❑Yes ❑No

c. Has the diagnosis been confirmed by a kidney biopsy? ❑Yes ❑No

d. Is the patient at risk of rapid disease progression as indicated by a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g? ❑Yes ❑No

e. Does the patient have an eGFR greater than or equal to 30 mL/min/1.73m^2? ❑Yes ❑No

f. Is the patient and prescriber enrolled in the Filspari REMS program? ❑Yes ❑No

g. Is Filspari being prescribed by or recommended by a nephrologist? ❑Yes ❑No

h. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to an ACE inhibitor or ARB? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Does the prescriber agree to monitor the patient's AST, ALT, and total bilirubin every 3 months during treatment? ❑Yes ❑No

b. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No

If YES, will the patient be advised to use effective contraception before treatment with Filspari and for one month after the last dose? ❑Yes ❑No

c. Has there been a decrease in the patient's urine protein-to-creatinine ratio (UPCR)? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Filspari – FEP MD Fax Form Revised 10/6/2023

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***