UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2301-4
Program	Prior Authorization/Medical Necessity
Medication	Filspari™ (sparsentan)
P&T Approval Date	4/2023, 10/2024, 6/2025, 7/2025
Effective Date	10/1/2025

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.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Filspari** will be approved based on **all** of the following:

   a. Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

   -AND-

   b. Patient is at risk of disease progression

   -AND-

   c. Used to slow kidney function decline

   -AND-

   d. Used to reduce proteinuria

   -AND-

   e. Estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73 m2

   -AND-

   f. **Both** of the following:

      1) Patient is on a maximized stable dose with **one** of the following prior to initiating therapy:

         a) maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)

b) maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

-AND-

2) Use of renin-angiotensin-aldosterone system (RAAS) inhibitors (e.g., ACE inhibitors, ARBs), endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer)], and Tekturna will be discontinued prior to initiating treatment

-AND-

g. History of failure (after a 30-day trial), contraindication or intolerance to a glucocorticoid (e.g., methylprednisolone, prednisone)

-AND-

h. History of failure (after a 30-day trial), contraindication or intolerance to a SGLT2 inhibitor (e.g., Jardiance)

-AND-

i. History of failure (after a 30-day trial), contraindication or intolerance to Vanrafia

-AND-

j. Prescribed by or in consultation with a nephrologist

Authorization will be issued for 12 months

B. Reauthorization

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

a. Documentation of positive clinical response demonstrated by a reduction in proteinuria

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.
- Supply limits may be in place.

4. References:

1. Filspari [package insert]. San Diego, CA: Traverse Therapeutics, Inc; April 2025.
2. KDIGO 2021 Glomerular Diseases Guideline. October 2021; 100 (4S).

Program	Prior Authorization/Medical Necessity – Filspari
Change Control	
Date	Change
4/2023	New program
10/2024	Updated disease progression criteria and criteria that use is to slow kidney decline. Updated references.
6/2025	Updated references.
7/2025	Added additional tried failed agents.