

Pharmacy Drug Policy & Procedure

Policy Name: Filspari (sparsentan)	Policy#:	3368P
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Purpose of the Policy

The purpose of this policy is to define coverage criteria for Filspari (sparsentan)

Statement of the Policy

Health Alliance Medical Plans will approve the use of Filspari (sparsentan) under the specialty pharmacy benefit if the following criteria are met.

Criteria

1. Coverage Criteria

- 1.1 Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by biopsy
- 1.2 Age 18 years or older
- 1.3 Prescribed by or in consultation with a nephrologist (kidney doctor) in the Filspari REMS program
- 1.4 eGFR >30 mL/min/1.73 m²
- 1.5 Total urine protein ≥ 1 g/day
- 1.6 Previous trial and failure of one generic RAS inhibitor (such as lisinopril or losartan) at maximally tolerated dose unless contraindicated

2. Exclusion Criteria

- 2.1 Pregnancy
- 2.2 Chronic kidney disease due to any other condition or currently receiving dialysis
- 2.3 Filspari will not be approved if being used in addition to angiotensin receptor blockers (ARBs), endothelin receptor antagonists (ERAs) or aliskiren or Tarpeyo

3. Managed Dose Limit

3.1 #30 tablets per 30 days

4. Approval Period

- 4.1 Initial: 12 months
- 4.2 Reauthorization: 12 months with documented benefit from therapy such as stabilization in kidney function, improvement in total urine protein or urine protein to creatinine ratio

CPT Codes	•	-	
HCPCS Codes			

References

1. Filspari (sparsentan) [prescribing information]. San Diego, CA: Travere Therapeutics, Inc; September

2024.

- 2. Heerspink HJL, Radhakrishnan J, Alpers CE, et al; PROTECT Investigators. Sparsentan in patients with IgA nephropathy: a prespecified interim analysis from a randomised, double-blind, active-controlled clinical trial. Lancet. 2023;401(10388):1584-1594.
- 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;100(4S):S1-S276.

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Revision Date:

DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.