Pharmacy Medical Necessity Guidelines: Filspari™ (sparsentan)

Effective: July 1, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION (FDA)-APPROVED INDICATIONS

Filspari (sparsentan) is an endothelin and angiotensin II receptor antagonist indicated to slow kidney function decline in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression. Filspari is also indicated to reduce proteinuria in adult and pediatric patients aged 8 years and older with focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome.

COVERAGE GUIDELINES

The plan may authorize coverage of **Filspari (sparsentan)** for Members, when the following criterion is met:

Immunoglobulin A Nephropathy

Initial Authorization Criteria

1. Documented diagnosis of immunoglobulin A nephropathy confirmed by kidney biopsy

AND

2. Documented urine protein-to-creatinine ratio (UPCR) of at least 1.5 g/g or proteinuria ≥ 1 g/day

AND

3. Documented estimated glomerular filtration rate of at least 30 mL/min/1.73 m^2

AND

4. Prescribed by or in consultation with a nephrologist

AND

5. Documentation the patient has not developed end stage renal disease by requiring either dialysis or a kidney transplant

AND

6. Documentation that the member has received at least 3 months of therapy with an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) (at up to maximally indicated doses), unless contraindicated or not tolerated

AND

7. Documentation that the member has received or is currently receiving at least 3 months of therapy with a sodium-glucose cotransporter-2 inhibitor (SGLT2i), unless contraindicated or not tolerated

AND

8. Documentation that the member has received optimized supportive care for at least 3 months, including blood pressure management, lifestyle modification, and cardiovascular risk modification

AND

9. Filspari is not used in combination with an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), endothelin receptor antagonist (ERA), or aliskiren

Reauthorization Criteria

1. Documented diagnosis of immunoglobulin A nephropathy confirmed by kidney biopsy

AND

2. Prescribed by or in consultation with a nephrologist

AND

3. Documentation of a positive clinical response as evidenced by a reduction in proteinuria

AND

4. Documentation the patient has not developed end stage renal disease by requiring either dialysis or a kidney transplant

Focal Segmental Glomerulosclerosis

Initial Authorization Criteria

1. Documented diagnosis of focal segmental glomerulosclerosis (FSGS) confirmed by kidney biopsy or genetic mutation known to cause FSGS

AND

2. Member is 8 years of age or older

AND

3. Documentation the member does not have nephrotic syndrome

AND

4. Documented urine protein-to-creatinine ratio (UPCR) of at least 1.5 g/g or proteinuria ≥ 1 g/day

AND

5. Documented estimated glomerular filtration rate of at least 30 mL/min/1.73 m^2

AND

6. Prescribed by or in consultation with a nephrologist

AND

7. Documentation that the member has received at least 3 months of therapy with an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) (at up to maximally indicated doses), unless contraindicated or not tolerated

AND

8. Documentation that the member has received or is currently receiving an immunosuppressive therapy (for example, prednisone, cyclosporine, tacrolimus, mycophenolate mofetil, azathioprine, etc), unless clinically inappropriate

AND

9. Filspari is not used in combination with an angiotensin-converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), endothelin receptor antagonist (ERA), or aliskiren

Reauthorization Criteria

1. Documented diagnosis of focal segmental glomerulosclerosis (FSGS) confirmed by kidney biopsy or genetic mutation known to cause FSGS

AND

2. Member is 8 years of age or older

AND

3. Documentation the member does not have nephrotic syndrome

AND

4. Prescribed by or in consultation with a nephrologist

AND

5. Documentation of a positive clinical response as evidenced by a reduction in proteinuria

LIMITATIONS

1. Initial coverage of Filspari will be authorized for 9 months. Reauthorization of Filspari will be provided in 12-month intervals.
2. Patients new to the plan stable on Filspari should be reviewed against Reauthorization Criteria.

CODES

None

REFERENCES

1. Filspari (sparsentan) [package insert]. San Diego, CA: Travere Therapeutics, Inc.; April 2026.
2. 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.

APPROVAL HISTORY

June 13, 2023: Reviewed by Pharmacy & Therapeutics Committee.

- May 14, 2024: No changes
- May 13, 2025: No changes
- August 12, 2025: Effective November 1, 2025: Updated coverage criteria to include proteinuria ≥ 1 g/day, 3-month trial of angiotensin converting enzyme inhibitor (ACEi), angiotensin receptor blocker (ARB), sodium-glucose cotransporter-2 inhibitor (SGLT2i), and supportive care, and Filspari not to be used in combination with ACEi, ARB, endothelin receptor antagonist, or aliksiren. Removal of lab value urine protein-to-creatinine ratio (UPCR) of at least 1.5 g/g from overview.

- June 9, 2026: Effective July 1, 2026, added coverage criteria for focal segmental glomerulosclerosis (FSGS). Updated overview based on expanded indication for slowing kidney function decline with IgAN and reducing proteinuria with FSGS.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services