maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Filspari

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Primary Immunoglobulin A Nephropathy (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
3	Has the diagnosis been confirmed by biopsy? [If no, no further questions.]	Yes	No
4	Does the patient have an estimated glomerular filtration rate GREATER THAN OR	Yes	No

If you have any questions, call:
1-888-258-8250

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	EQUAL TO 30 mL/min/1.73 m2? [If no, no further questions.]		
5	Is the requested medication being used in combination with any renin-angiotensin-aldosterone antagonists (for example, angiotensin converting enzyme inhibitors or angiotensin receptor blockers), endothelin receptor antagonists, or aliskiren? [Note: Examples of angiotensin converting enzyme inhibitors include but are not limited to lisinopril, fosinopril, enalapril, benazepril. Examples of angiotensin receptor blockers include but are not limited to irbesartan, losartan, candesartan, valsartan.] [If yes, no further questions.]	Yes	No
6	Does the dose of the requested medication exceed Food and Drug Administration (FDA) approved label dosing for indication? [If yes, no further questions.]	Yes	No
7	Is the requested medication prescribed by or in consultation with a nephrologist? [If no, no further questions.]	Yes	No
8	Is the patient currently receiving the requested medication? [If no, skip to question 13.]	Yes	No
9	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 13.]	Yes	No
10	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 12.]	Yes	No
11	Has the patient had a response to the requested medication, according to the prescriber? [Note: Examples of a response are reduction in urine protein-to-creatinine ratio from baseline, reduction in proteinuria from baseline.] [No further questions.]	Yes	No
12	Has documentation been provided to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Does the patient have proteinuria GREATER THAN 1.0 g/day? [If yes, skip to question 15.]	Yes	No
14	Does the patient have urine protein-to-creatinine ratio GREATER THAN OR EQUAL TO 1.5 g/g?	Yes	No

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	[If no, no further questions.]		
15	Has the patient received the maximum or maximally tolerated dose of angiotension converting enzyme inhibitor for GREATER THAN OR EQUAL TO 12 weeks prior to starting the requested medication? [If yes, skip to question 17.]	Yes	No
16	Has the patient received the maximum or maximally tolerated dose of angiotensin receptor blocker for GREATER THAN OR EQUAL TO 12 weeks prior to starting the requested medication? [If no, no further questions.]	Yes	No
17	Has the patient received GREATER THAN OR EQUAL TO 3 months of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification, according to the prescriber? [If no, no further questions.]	Yes	No
18	Does the patient have history of failure, contraindication to or intolerance to TWO glucocorticoids used for at least 2 months?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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