



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Filspari

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: ☐ Medicaid ☐ CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:		Diagnosis:	
Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the medication being prescribed by or in consultation with a nephrologist?

☐ Yes

☐ No

Q2. Is this an initial request or re-authorization request?

☐ Initial request

☐ Re-authorization request

Q3. What is the diagnosis?

☐ Primary Immunoglobulin A Nephropathy (IgAN)

☐ Other

Q4. If other, please specify:

Q5. Does the member have a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy (with results attached)?

☐ Yes

☐ No



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Member Name:

Prescriber Name:

Q6. Does the member have either of the following obtained within 3 months prior to initiation of the requested drug? Lab reports or chart notes with results must be included.

- ☐ Proteinuria greater than or equal to 0.5 g/day
☐ UPCR greater than or equal to 0.8 g/g
☐ None of the above

Q7. Has the member received a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or angiotensin II receptor blocker [ARB]) for at least 3 months prior to initiation of therapy, or does the member have an intolerance or contraindication to RAS inhibitors?

- ☐ Yes ☐ No

Q8. Will the member use the requested medication concomitantly with ARB, endothelin receptor antagonists [ERA] or renin-angiotensin-aldosterone system [RAAS] (i.e., aliskiren)?

- ☐ Yes ☐ No

Q9. Is the member experiencing benefit from therapy as evidenced by either of the following? Lab reports or chart notes with results must be included.

- ☐ Decreased levels of proteinuria from baseline
☐ Decrease in UPCR from baseline
☐ None of the above

Q10. Additional Information:

Prescriber Signature

Date

v2026-06