Commercial PA Criteria

Effective: May 8, 2025

Prior Authorization: Vanrafia (atrasentan)

Products Affected: Vanrafia (atrasentan) oral tablet

Medication Description: VANRAFIA is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g.

Covered Uses: Primary immunoglobulin A nephropathy (IgAN)

Exclusion Criteria:

1. Concurrent use with other medications indicated for the treatment of immunoglobulin A nephropathy (e.g., Fabhalta and Filspari).
2. Contraindicated in patients who are pregnant

Required Medical Information:

1. Diagnosis
2. Medical History
3. Medication History

Prescriber Restriction: The medication is prescribed by, or on consultation with, a nephrologist.

Age Restriction: Patient must be 18 years of age or older

Coverage Duration: 9 months

Other Criteria:

Initial Approval Criteria

1. Primary Immunoglobulin A Nephropathy. Approve if the patient meets **ONE** of the following (A or B):

A. Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, iv, v, and vi):

i. Patient is ≥ 18 years of age; **AND**

ii. The diagnosis has been confirmed by biopsy; **AND**

iii. Patient is at high risk of disease progression, defined by meeting **BOTH** of the following (a and b):

a. Patient meets **ONE** of the following [(1) or (2)]:

(1) Proteinuria ≥ 0.5 g/day; **OR**

(2) Urine protein-to-creatinine ratio ≥ 1.5 g/g; **AND**

b. Patient has received or is currently receiving the maximum or maximally tolerated dose of **ONE** of the following for ≥ 12 weeks prior to starting Vanrafia [(1) or (2)]:

(1) Angiotensin converting enzyme inhibitor; **OR**

(2) Angiotensin receptor blocker; **AND**

iv. According to the provider, patient has received ≥ 3 months of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification; **AND**

v. Patient has an estimated glomerular filtration rate ≥ 30 mL/min/1.73 m^2; **AND**

vi. The medication is prescribed by or on consultation with a nephrologist; **OR**

B. Patient is Currently Receiving Vanrafia. Approve if the patient meets **ALL** of the following (i, ii, iii, iv, and v):
   i. Patient is ≥ 18 years of age; **AND**
   ii. The diagnosis has been confirmed by biopsy; **AND**
   iii. According to the prescriber, patient has had a response to Vanrafia,; **AND**
   Note: Examples of a response are a reduction in urine protein-to-creatinine ratio from baseline, reduction in proteinuria from baseline.
   iv. Patient has an estimated glomerular filtration rate ≥ 30 mL/min/1.73 m^2; **AND**
   v. The medication is prescribed by or on consultation with a nephrologist

References:

1. Vanrafia™ tablets [prescribing information]. East Hanover, NJ: Novartis; April 2025.

Policy Revision history

Rev #	Type of Change	Summary of Change	Sections Affected	Date
1	New Policy	New Policy	All	05/08/2025