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AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

DUR MEDICATION VANRAFIA™ (atrasentan) and VOYXACT® (sibeprenlimab-szsi)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

VANRAFIA™ or VOYXACT® – to receive a 9-month approval for this drug, complete the following questions.

1. Is the prescriber a specialist in the area of the member's diagnosis (e.g., nephrologist) or has the prescriber consulted with a specialist in the area of the member's diagnosis?

   ☐ Yes ☐ No

2. Is the member 18 years of age or older?

   ☐ Yes ☐ No

3. Does the member have a diagnosis of primary immunoglobin A nephropathy (IgAN) confirmed by kidney biopsy?

   ☐ Yes ☐ No

4. Does the member have **one** of the following:

   a. Member has proteinuria ≥ 0.5 g/day; **OR**

   b. Member has a urine protein-to-creatinine ratio (UPCR) ≥ 0.44 g/g?

   ☐ Yes ☐ No

5. Does the member have an estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73 m^2?

   ☐ Yes ☐ No

6. Does the member have one of the following:

   a. The member is taking a maximally tolerated angiotensin-converting enzyme inhibitor (ACEI) (e.g., benazepril, lisinopril) or angiotensin II blocker (ARB) (e.g., losartan) or a combination medication containing an ACEI or ARB for at least a 90-day duration of therapy **and** the member will continue maximally tolerated ACEI or ARB, or combination medication containing an ACEI or ARB, in combination with Vanrafia or Voyxact; **OR**

   b. The member has an intolerance, hypersensitivity, or FDA-labeled contraindication to all ACEIs or ARBs, or combination medications containing an ACEI or ARB?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

For VANRAFIA:

7. Does the member have severe hepatic impairment (Child-Pugh Class C)?

   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 1-year approval:

8. Does the member continue to meet the above criteria (questions 1 through 6 for Voyxact and questions 1–7 for Vanrafia)?

   ☐ Yes ☐ No

9. Does the member continue to experience clinical benefit from the requested treatment?

   ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.