

Filspari (sparsentan)
Effective 10/01/2026

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange		Program Type	☒ Prior Authorization
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit			☐ Quantity Limit ☐ Step Therapy
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.			
Contact Information	Medical Benefit	Phone: 833-895-2611	Fax: 888-656-6671	
	Pharmacy Benefit	Phone: 800-711-4555	Fax: 844-403-1029	
Exceptions	N/A			

Overview

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 disease progression
- to reduce proteinuria in adult and pediatric patients aged 8 years and older with focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome

Prior to initiating treatment with Filspari, use of renin-angiotensin-aldosterone system (RAAS) inhibitors and endothelin receptors antagonists (ERAs) should be discontinued.

Coverage Guidelines

If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted all of the following diagnosis-specific criteria are met:

Immunoglobulin A nephropathy (IgAN)

1. Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy
2. Member is at risk for disease progression
3. Estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/minute/1.73m²
4. Member has received at least a 3-month trial with a renin-angiotensin system (RAS) inhibitor (e.g., angiotensin converting enzyme inhibitor [ACEI], angiotensin II receptor blocker [ARB]) at a maximally tolerated dose, unless the member has had an intolerance, adverse effect, or contraindication

Focal Segmental Glomerulosclerosis (FSGS)

1. Diagnosis of focal segmental glomerulosclerosis
2. Requested medication will be used to reduce proteinuria
3. Member is 8 years of age or older
4. Member does not have nephrotic syndrome

Continuation of Therapy

Requests for reauthorization will be approved when all of the following diagnosis-specific criteria are met:

Immunoglobulin A nephropathy (IgAN)

1. Submission of medical records (e.g., chart notes) documenting member has had a positive clinical response to therapy as evidenced by ONE of the following:
 - a. Decreased levels of proteinuria from baseline on a 24-hour urine collection
 - b. Decrease in UPCR from baseline based on 24-hour urine collection

Focal Segmental Glomerulosclerosis (FSGS)

1. Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., Urine Protein-Creatinine Ratio [UPCR] reduction from baseline)

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.
2. The following quantity limitations apply:

Drug Name and Dosage Form	Quantity Limit
Filspari 200 mg tablet	1 tablet per day
Filspari 400 mg tablet	2 tablets per day

References

1. Filspari (sparsentan) [prescribing information]. San Diego: Travele 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 Oct; 100 (4S): S1-S276. doi: 10.1016/j.kint.2021.05.021.
3. Rovin BH, Barratt J, Heerspink HJL, et al. Efficacy and safety of sparsentan versus irbesartan in patients with IgA nephropathy (PROTECT): 2-year results from a randomized, active-controlled, phase 3 trial. *Lancet.* 2023;402:2077-2090.

Review History

06/14/2023 - Reviewed at June P&T, Effective 8/1/23

11/15/2023 – Reviewed at Nov P&T; No clinical changes.

12/11/2024 – Reviewed and updated at December P&T. Updated “medical records” to “documentation.”

Removed requirement that the member is intolerant to glucocorticoids from initial criteria. Updated reauthorization criteria to require documentation of benefit. Effective 3/1/2025.

08/13/2025 – Reviewed and updated at August P&T. Added quantity limits to policy. Removed documentation requirements from initial criteria. Effective 11/01/2025.

10/08/2025 – Reviewed and updated at October P&T. Updated verbiage for ACEI/ARB trial. Effective 01/01/2026.

02/11/2026 – Reviewed and updated at February P&T. Removed minimum proteinuria level requirement and require that member is at risk for disease progression. Added minimum eGFR to the initial criteria. Effective 05/01/2026.

07/15/2026 – Reviewed and updated at June P&T. Added supplemental indication of FSGS to the policy. Updated quantity limit for 400 mg tablet. Effective 10/01/2026.

