



## Drug Coverage Policy

Effective Date ..... 6/1/2024  
Coverage Policy Number.....IP0565  
Policy Title.....Filspari

### Nephrology – Filspari

- Filspari™ (sparsentan tablets – Travere)

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### Cigna Healthcare Coverage Policy

Filspari, an endothelin and angiotensin II receptor antagonist, 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)  $\geq 1.5$  g/g.<sup>1</sup> This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether Filspari slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

Filspari is contraindicated for use with renin-angiotensin-aldosterone system (RAAS) inhibitors, endothelin receptor antagonists (ERAs), or aliskiren.<sup>1</sup> RAAS inhibitors, ERAs, and/or aliskiren must be discontinued prior to initiation of Filspari.

#### Clinical Efficacy

The efficacy of Filspari is being assessed in an ongoing Phase III trial in adults with biopsy-proven IgAN, proteinuria  $\geq 1.0$  g/day at screening, and estimated glomerular filtration rate (eGFR)  $\geq 30$  mL/min/1.73 m<sup>2</sup> (PROTECT, n = 404).<sup>2</sup> Additionally patients were receiving the maximum tolerated dose (at least one-half of the maximum labeled dose) of an angiotensin converting enzyme inhibitor (ACEi) or angiotensin receptor blocker (ARB) for  $\geq 12$  weeks prior to study entry and had blood pressure of  $\leq 150/100$  mmHg (managed according to standard of care). Patients with use of immunosuppressive medications (including corticosteroids for  $> 2$  weeks within 3 months of screening), chronic kidney disease (CKD) in addition to IgAN, or IgAN secondary to other conditions were excluded. Per study protocol, patients discontinued their ACEi or ARB 1 day prior to the start of Filspari.<sup>2</sup>

The primary efficacy endpoint was the change from baseline in urine protein-to-creatinine ratio (based on 24-hour urine sample) at Week 36.<sup>2</sup> The primary analysis was based on an interim data cutoff of August 1, 2021. At Week 36, the primary endpoint was significantly greater with Filspari vs. irbesartan in the interim analysis set (comprised of the first 281 patients randomized in the study, including 2 patients who were not treated); the geometric least squares mean percent change in UPCR from baseline was -45% vs. -15%, respectively. This resulted in a statistically significant relative reduction from baseline in UPCR for the Filspari vs. irbesartan group (geometric mean ratio 0.7; 95% confidence interval [CI]: 0.6, 0.8; P < 0.0001), corresponding to a 35% relative reduction with Filspari. Supportive secondary endpoints for changes in UPCR from baseline to Week 94 and urine albumin-to-creatinine ratio (UACR) from baseline to Weeks 36 and 94, were significantly greater with Filspari. A confirmed 40% reduction in eGFR, end-stage kidney disease, or death was reported in a smaller proportion of patients treated with Filspari (3.5%) vs. irbesartan (6.4%) [P = not estimable].

Several exploratory endpoints also favored Filspari over irbesartan. At the interim analysis (Week 36), the proportion of patients in the Filspari group who achieved partial proteinuria remission ( $< 1$  g/day) was significantly higher with Filspari vs. irbesartan (55% vs. 24%, respectively) and numerically more patients in the Filspari vs. irbesartan group (11% vs. 4%, respectively) achieved complete proteinuria remission ( $< 0.3$  g/day) at Week 36.

## **Guidelines**

Kidney Diseases: Improving Global Outcomes (KDIGO) clinical practice guidelines for the management of glomerular diseases (2021) mention Filspari as an investigational agent.<sup>3</sup> Therapeutic strategies that minimize or avoid systemic glucocorticoid exposure are considered areas of priority for future research to improve the treatment and outcomes of patients with IgAN, and the PROTECT trial is mentioned. Filspari is also mentioned for children with steroid-resistant nephrotic syndrome. For children with calcineurin inhibitor-resistant, steroid-resistant nephrotic syndrome, consideration for entry into clinical trials evaluating novel therapies on the horizon should be strongly considered.

Following biopsy-confirmed diagnosis of IgAN, the guidelines recommend assessment of disease progression.<sup>3</sup> The primary focus of IgAN treatment should include multiple modalities such as RAAS blockage (maximum dose or maximum tolerated dose), blood pressure control, cardiovascular risk minimization, and adherence to lifestyle advice (i.e., dietary counseling, smoking cessation, weight control, and exercise as appropriate). RAAS blockade (with either an ACEi or ARB) is recommended regardless of hypertension if a patient has proteinuria  $> 0.5$  g/day (500 mg/day). There are no data to suggest that dual blockade with an ACEi and ARB is superior to single blockade. In patients who remain at high risk of progressive CKD despite maximal supportive care, a 6-month course of glucocorticoid therapy should be considered.

## **Safety**

Filspari has a Black Box Warning and Risk Evaluation and Mitigation Strategy (REMS) program around hepatotoxicity and embryo-fetal toxicity.<sup>1,4</sup> The three objectives of the REMS are to monitor for elevations in liver enzymes in patients exposed to Filspari, ensure that patients who can become pregnant are not pregnant before initiating Filspari, and to minimize exposure in patients who may become pregnant while taking Filspari.

## Medical Necessity Criteria

**Filspari is considered medically necessary when the following are met:**

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

A. Initial Therapy. Approve for 9 months if the patient meets the following (i, ii, iii, iv, v, vi, and vii):

- i. Patient is  $\geq 18$  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 the following criteria (a and b):
  - a. Patient meets ONE of the following [(1) or (2)]:
    - (1) Proteinuria  $> 1.0$  g/day; OR
    - (2) Urine protein-to-creatinine ratio  $\geq 1.5$  g/g; AND
  - b. Patient has received the maximum or maximally tolerated dose of ONE of the following for  $\geq 12$  weeks prior to starting Filspari [(1) or (2)]:
    - (1) Angiotensin converting enzyme inhibitor; OR
    - (2) Angiotensin receptor blocker; AND
- iv. Patient has received  $\geq 3$  months of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification, according to the prescriber; AND
- v. Patient has an estimated glomerular filtration rate  $\geq 30$  mL/min/1.73 m<sup>2</sup>; AND
- vi. The medication will not be used in combination with any renin-angiotensin-aldosterone antagonists (e.g., angiotensin converting enzyme inhibitors or angiotensin receptor blockers), endothelin receptor antagonists, or aliskiren; AND  
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.
- vii. The medication is prescribed by or on consultation with a nephrologist.

B) Patient is Currently Receiving Filspari. Approve for 1 year if the patient meets the following (i, ii, iii, iv, v, and vi):

- i. Patient is  $\geq 18$  years of age; AND
- ii. The diagnosis has been confirmed by biopsy; AND
- iii. Patient has had a response to Filspari, according to the prescriber; 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  $\geq 30$  mL/min/1.73 m<sup>2</sup>; AND
- v. The medication is not being used in combination with any renin-angiotensin-aldosterone antagonists (e.g., angiotensin converting enzyme inhibitors or angiotensin receptor blockers), endothelin receptor antagonists, or aliskiren; AND  
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.
- vi. The medication is prescribed by or on consultation with a nephrologist.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

## Conditions Not Covered

Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available).

## References

1. Filspari™ tablets [prescribing information]. San Diego, CA: Travere; February 2023.
2. Sparsentan for Primary IgAN, Formulary Dossier. Version 4.1 Travere. February 18, 2023
3. Kidney Diseases: Improving Global Outcomes (KDIGO) 2021 clinical practice guidelines for the management of glomerular diseases. *Kidney Int.* 2021;100:S1-S276. Available at: <https://www.kidney-international.org/action/showPdf?pii=S0085-2538%2821%2900562-7>. Accessed on February 12, 2024.
4. The Filspari™ REMS (Risk Evaluation and Mitigation Strategy). Available at: <https://filsparirems.com/#Main>. Accessed on: February 12, 2024.

## Revision Details

Type of Revision	Summary of Changes	Date
Annual Review	<b>Primary Immunoglobulin A Nephropathy.</b> (1) Added 'Patient is currently receiving Filspari' criteria. (2) Updated high risk of disease progression criteria.	6/1/2024

The policy effective date is in force until updated or retired.

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