[This letter should be written on practice letterhead after fully reviewing the health plan's medical policy]

[Date]:

[Insurance Company]

[Street Address, City]

[State, ZIP Code]

Patient Name: [XXXXXXX]

Policy #: [XXXXXXXX]

Group #: [XXXXXXXX]

Date of Birth: [XXXXXXXXXX]

RE: Statement of Medical Necessity for FILSPARI® (sparsentan)

To Whom It May Concern:

I am writing on behalf of [insert patient name] to request prior authorization and provide documentation of the medical necessity for treatment with FILSPARI® (sparsentan). The patient was referred to me by [if applicable, insert referring physician]. [Insert a brief statement about the patient's diagnosis, medical history, and the severity of their condition.]

Following is a list of the patient's current and past medications.

Treatment(s)	Start Date	Stop Date	Discontinuation Reason

I have reviewed the FILSPARI® (sparsentan) Prescribing Information and based on my clinical judgment, I believe the following treatment plan is indicated and medically necessary for [insert patient name]:

[Insert medication, dosage, quantity, estimated duration of therapy, and drug NDC number].

If you require additional information, please contact me at [Physician's telephone and office email]. Please note the following attachments:

- Relevant clinical documentation to support medication use – medical records, progress notes, and lab reports. For example, record of kidney biopsy, current proteinuria & eGFR levels, documented use of RAASi, REMS enrollment confirmation, etc.
- Prescribing Information
- FDA Product Approval Letter

Thank you for your consideration. Sincerely,

[Insert Physician's Name]