[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]

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