PARAMOUNT
Affiliate of ProMedica

CRITERIA: PMT
APPROVED:
VERIFIED: 5/2022
REVIEWED:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Tarpeyo

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025.** You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Tarpeyo.

Brand Name (select from list of drugs shown)

Tarpeyo (budesonide delayed release capsules)

Quantity _____ Frequency _____ Strength_____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1	Does the patient have a diagnosis of Idiopathic IgAN? [If no, no further questions.]	Yes	No
2	Is this a request for continuation of therapy? [If yes, skip to question 9.]	Yes	No
3	Was the diagnosis confirmed by a kidney biopsy and urine protein-creatine-ratio (UPCR) of > = 1.5 g/g?	Yes	No

[If no, no further questions.]

4	Is the patient at a high risk for disease progression with proteinuria > 0.75-1 g/d despite greater than 90 days of optimized supportive care (i.e. ACEI or ARB)? [If no, no further questions.]	Yes	No
5	Were secondary causes of IgAN ruled out (i.e. IgA vasculitis, IgAN secondary to HIV, hepatitis, inflammatory bowel, liver cirrhosis; and IgA-dominant infection-related GN)? [If no, no further questions.]	Yes	No
6	Is the prescriber a nephrologist? [If no, no further questions.]	Yes	No
7	Is the patient at least 18 years of age or older? [If no, no further questions.]	Yes	No
8	Will the dose and length of treatment follow the FDA label with a max dosage of 16mg per day for 9 months which includes a two-week taper of 8mg/day at end of treatment? [No further questions.]	Yes	No
9	Has the patient seen a reduction in proteinuria during treatment with a target of under 1 g/d and this was assessed at 3 months and 6 months of therapy?	Yes	No

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date