AETNA BETTER HEALTH® Coverage Policy/Guideline			
Name:	Vanrafia	Page:	1 of 2
Effective Date:	6/20/2025	Last Review Date:	5/22/2025
Applies to:	☒Illinois ☒Florida Kids	☒New Jersey ☒Pennsylvania Kids	☒Maryland ☒Virginia

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Vanrafia under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Vanrafia 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) greater than or equal to 1.5 grams per gram (g/g).

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Vanrafia

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

- Initial requests:
  - Kidney biopsy confirming a diagnosis of primary immunoglobulin A nephropathy (IgAN).
  - Laboratory report and/or chart note(s) indicating the member has proteinuria greater than or equal to 1 gram per day (g/day) or baseline urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.8 grams per gram (g/g).
- Continuation requests:
  - Laboratory report and/or chart note(s) indicating the member has decreased levels of proteinuria or UPCR from baseline.

Coverage Criteria

Primary Immunoglobulin A Nephropathy (IgAN)

Authorization of 12 months may be granted when ALL the following criteria are met:

- Member has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy.
- Member has either of the following:
  - Proteinuria greater than or equal to 1 g/day;
  - UPCR greater than or equal to 0.8 g/g
- Member is receiving a stable dose of maximally tolerated renin-angiotensin system (RAS) inhibitor therapy (e.g., angiotensin converting enzyme inhibitor [ACEI] or

angiotensin II receptor blocker [ARB]) for at least 3 months of therapy, or member has an intolerance or contraindication to RAS inhibitors.

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in all members (including new members) who are currently receiving the requested medication and who are experiencing benefit from therapy as evidenced by EITHER of the following:

- Decreased levels of proteinuria from baseline.
- Decrease in UPCR from baseline.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

1. Vanrafia [package insert]. East Hanover, New Jersey: Novartis Pharmaceuticals Corporation; April 2025.
2. ClinicalTrial.gov. National Library of Medicine (US). Identifier NCT04573478 Atrasentan in Patients with IgA Nephropathy (ALIGN). October 15, 2024. Available from: https://clinicaltrials.gov/study/NCT04573478.
3. 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.