Effective Date: 09/10/2025
Current Effective Date: 09/10/2025
Last P&T Approval/Version: 07/30/2025
Next Review Due By: 07/2026
Policy Number: C29620-A

Vanrafia (atrasentan)

PRODUCTS AFFECTED

Vanrafia (atrasentan)

COVERAGE POLICY

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Coverage Guideline must be read in its entirety to determine coverage eligibility, if any. This Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide Molina Healthcare complete medical rationale when requesting any exceptions to these guidelines.

Documentation Requirements:
Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

DIAGNOSIS:
Primary immunoglobulin A nephropathy (IgAN)

REQUIRED MEDICAL INFORMATION:
This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. If a drug within this policy receives an updated FDA label within the last 180 days, medical necessity for the member will be reviewed using the updated FDA label information along with state and federal requirements, benefit being administered and formulary preferencing. Coverage will be determined on a case-by-case basis until the criteria can be updated through Molina Healthcare, Inc. clinical governance. Additional information may be required on a case-by-case basis to allow for adequate review. When the requested drug product for coverage is dosed by weight, body surface area or other member specific measurement, this data element is required as part of the medical necessity review. The Pharmacy and Therapeutics Committee has determined that the drug benefit shall be a mandatory generic and that generic drugs will be dispensed whenever available.

A. PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN):
   1. Documented diagnosis of Primary Immunoglobulin A Nephropathy (IgAN)
      AND
   2. Documentation diagnosis was confirmed by kidney biopsy
      AND

3. Documentation that member has failed to achieve a reduction in proteinuria under 1 gram/day while receiving maximally tolerate doses of a Renin-angiotensin-system (RAS) inhibitor (ACE inhibitor or ARB) for at least 3 months
   AND
4. Documentation that member has had a trial and failure of ONE formulary preferred glucocorticoid for at least 2 months
   AND
5. Documentation that member's urine protein-to-creatinine ratio [UPCR] is ≥1.5 (consistent with FDA-approved labeling) and eGFR ≥30 mL/min/1.73 m2
   NOTE: UPCR ≥ 1.5 indicates a risk of rapid progression
   AND
6. Member is not currently receiving dialysis or has not undergone kidney transplant.
   AND
7. Prescriber attests to (or clinical reviewer has found that) the member not having any FDA labeled contraindications that haven't been addressed by the prescriber within the documentation submitted for review [Contraindications to Vanrafia (atrasentan) include: Pregnancy and hypersensitivity, do not initiate Vanrafia in patients with severe hepatic impairment, avoid concomitant use with a strong or moderate CYP3A inducer, avoid concomitant use with organic anion transporting polypeptides 1B1/1B3 (OATP1B1/1B3) inhibitors.]

CONTINUATION OF THERAPY:

A. PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IgAN):

1. Adherence to therapy at least 85% of the time as verified by the prescriber or member medication fill history OR adherence less than 85% of the time due to the need for surgery or treatment of an infection, causing temporary discontinuation
   AND
2. Prescriber attests to or clinical reviewer has found no evidence of intolerable adverse effects or drug toxicity
   AND
3. Documentation of positive clinical response as demonstrated by low disease activity and/or improvements in the condition's signs and symptoms

DURATION OF APPROVAL:

Initial authorization: 6 months, Continuation of Therapy: 12 months

PRESCRIBER REQUIREMENTS:

Prescribed by or in consultation with a board-certified nephrologist [If prescribed in consultation, consultation notes must be submitted with initial request and reauthorization requests]

AGE RESTRICTIONS:

18 years of age and older

QUANTITY:

0.75 mg by mouth once daily

PLACE OF ADMINISTRATION:

The recommendation is that oral medications in this policy will be for pharmacy benefit coverage and patient self-administered.

DRUG INFORMATION

ROUTE OF ADMINISTRATION:

Oral

DRUG CLASS:
IgAN Agents - Endothelin Receptor Antagonist

FDA-APPROVED USES:
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) ≥ 1.5 g/g.
This indication is approved under accelerated approval based on a reduction of proteinuria. It has not been established whether Vanrafia 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.

COMPENDIAL APPROVED OFF-LABELED USES:
None

APPENDIX

APPENDIX:
None

BACKGROUND AND OTHER CONSIDERATIONS

BACKGROUND:
Immunoglobulin A nephropathy (IgAN) is an autoimmune disorder that affects the kidneys, where abnormal IgA antibodies accumulate in the glomeruli, the filtering units of the kidneys, leading to inflammation and tissue damage. This disruption in kidney function causes blood and protein to leak into the urine. Although the precise cause remains unclear, the condition begins when the body produces faulty IgA antibodies. These are mistakenly identified as threats by the immune system, triggering the formation of immune complexes that deposit in the kidneys. These deposits are often more active during infections, particularly respiratory infections, increasing inflammation and accelerating kidney injury.

Per the KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases, kidney biopsy is the “gold standard” for diagnostic evaluation of glomerular disease. The guideline further notes that IgAN can only be diagnosed with a kidney biopsy (Chapter 2, reference 3). Additionally, the use of an ACE inhibitor or ARB up to a maximally tolerated or allowed dose is considered first line therapy for the treatment of hypertension and proteinuria. The guideline defines a high risk for progressive disease as proteinuria greater than 0.75 to 1 gram despite the use of optimized supportive care, including an ACE inhibitor or ARB, for at least 90 days. For those patients who remain at high risk of progressive CKD despite the maximized supportive care, immunosuppressive drugs should be considered. Vanrafia received accelerated approval for the indication of IgAN and confirmatory studies are ongoing.

Studied against placebo in a multicenter, randomized, double-blind study (ALIGN), Vanrafia was found to reduce proteinuria 38.1% over placebo (-38.1% for Vanrafia vs. -3.1% for placebo reduction from baseline) after 36 weeks of treatment.

CONTRAINDICATIONS/EXCLUSIONS/DISCONTINUATION:
All other uses of Vanrafia (atrasentan) are considered experimental/investigational and therefore, will follow Molina’s Off- Label policy. Contraindications to Vanrafia (atrasentan) include: Pregnancy and hypersensitivity, do not initiate Vanrafia in patients with severe hepatic impairment, avoid concomitant use with a strong or moderate CYP3A inducer, avoid concomitant use with organic anion transporting polypeptides 1B1/1B3 (OATP1B1/1B3) inhibitors.

Exclusions/Discontinuation:

Discontinue Vanrafia for:

- Pregnancy
- Hepatotoxicity (clinically significant elevations in aminotransferase or bilirubin)

OTHER SPECIAL CONSIDERATIONS:

Vanrafia (atrasentan) has a Black Box Warning for embryo-fetal toxicity: Vanrafia may cause major birth defects if used during pregnancy. Exclude pregnancy before initiating treatment. Patients should use effective contraception prior to starting Vanrafia, throughout treatment, and for at least two weeks after the last dose. Discontinue Vanrafia immediately if pregnancy occurs.

CODING/BILLING INFORMATION

CODING DISCLAIMER. *Codes listed in this policy are for reference purposes only and may not be all-inclusive or applicable for every state or line of business. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry-standard coding practices for all submissions. Molina has the right to reject/deny the claim and recover claim payment(s) if it is determined it is not billed appropriately or not a covered benefit. Molina reserves the right to revise this policy as needed.*

HCPCS CODE	DESCRIPTION
NA	

AVAILABLE DOSAGE FORMS:

Vanrafia TABS 0.75MG

REFERENCES

1. Vanrafia (atrasentan) tablets, for oral use [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2025.
2. Novartis Pharmaceuticals Corporation. Study to evaluate the efficacy and safety of atrasentan in patients with IgA nephropathy (ALIGN). www.clinicaltrials.gov/study/NCT04573478. NLM identifier: NCT04573478.
3. Novartis Pharmaceuticals Corporation. Study to evaluate the efficacy and safety of atrasentan in patients with diabetic kidney disease (SONAR). www.clinicaltrials.gov/study/NCT01858532. NLM identifier: NCT01858532.
4. Kidney Disease: Improving Global Outcomes (KDIGO) Glomerular Diseases Work Group. KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases. Kidney Int. 2021;100(4S):S1–S276.
5. Lv, J., Wong, M. G., Hladunewich, M. A., Jha, V., Hooi, L. S., Monaghan, H., Zhao, M., Barbour, S., Jardine, M. J., Reich, H. N., Cattran, D., Glassock, R., Levin, A., Wheeler, D. C., Woodward, M., Billot, L., Stepien, S., Rogers, K., Chan, T. M., Liu, Z. H., … TESTING Study Group (2022). Effect of Oral Methylprednisolone on Decline in Kidney Function or Kidney Failure in Patients With IgA Nephropathy: The TESTING Randomized Clinical Trial. JAMA, 327(19), 1888–1898. https://doi.org/10.1001/jama.2022.5368
6. Caravaca-Fontán, F., Gutiérrez, E., Sevillano, Á. M., & Praga, M. (2023). Targeting complement in IgA

nephropathy. Clinical Kidney Journal, 16(Supplement_2), ii28–ii39. https://doi.org/10.1093/ckj/sfad198
7. Li J, Wang Y, Zhang H, et al. Efficacy and safety of endothelin A receptor antagonists in IgA nephropathy: a systematic review and meta-analysis. www.ncbi.nlm.nih.gov/pmc/articles/PMC11932335. PMC ID: PMC11932335.

SUMMARY OF REVIEW/REVISIONS	DATE
NEW CRITERIA CREATION	Q3 2025