Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Budesonide (Tarpeyo) – Medical Necessity Request

****Complete page 1 for New Requests ****

1. Does the member have a diagnosis of immunoglobulin A nephropathy (e.g., Berger's disease)?
   - □ **Yes**
   - □ **No** – Please provide the diagnosis: _____

2. Has the diagnosis been confirmed by a kidney biopsy? **Yes or No**

3. Has the member tried and failed therapy with a maximum tolerated angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) (e.g., benazepril, lisinopril, losartan)?
   - □ **Yes** - Please provide the name, strength, and dates of trial of the medication: _____
     _____
   - □ **No -** Can the member try maximum tolerated angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB) (e.g., benazepril, lisinopril, losartan) instead?
     - □ **Yes**: Please notify the pharmacy of the change and return the form.
     - □ **No:** Please provide the reason why: _____
       _____

4. Does the member have a urine protein-to-creatinine ratio (UPCR) of ≥1.5 g/g? **Yes or No**

5. Does the member have proteinuria greater than or equal to 1 g/day? **Yes or No**

6. Does the member have an eGFR ≥35 mL/min/1.73 m^2? **Yes or No**

7. Is the medication being prescribed by a physician specialty that specializes in immunoglobulin A nephropathy (e.g., nephrologist)?
   - □ **Yes**
   - □ **No** – Please provide the name of the specialty: _____

8. Has the member received therapy with Tarpeyo?
   - □ **Yes** – How many weeks? _____
   - □ **No**

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**