



FILSPARI® Patient Start Form for IgAN and FSGS



The Start Form acts as a prescription and enrolls patients in the Traverse TotalCare® program

For more information about FILSPARI, please visit FILSPARIhcp.com, and for additional information regarding REMS, visit FILSPARIREMS.com.

Fully complete the **FILSPARI® (sparsentan)** Patient Start Form to get your patients started on treatment



The Start Form can be used for both FILSPARI starting and maintenance prescriptions.

IMPORTANT TIPS

- ✓ In order to prescribe FILSPARI, you must complete and submit a REMS Enrollment Form for each patient
- ✓ Enter the office contact's email address to receive the electronic prior authorization notification
- ✓ Check the appropriate diagnosis box
- ✓ Complete the FILSPARI prescription and choose the QuickStart*/Bridge Program,† if applicable
- ✓ After you and your patient review the form together, have your patient sign and date the form while in the office
- ✓ Based on the table below, select the appropriate prescription for either IgAN or FSGS

Dosing Guidelines by Indication ¹	IgAN ¹	FSGS >50 kg/>110 lb ¹	FSGS ≤50 kg/≤110 lb ¹
Starting Dose (PO QD)	200 mg	400 mg	200 mg
Recommended Dose (PO QD)	400 mg	800 mg	400 mg

Diagnosis ²	ICD-10 Code ²	Description ²
Primary IgAN	N02.B	Recurrent and persistent immunoglobulin A nephropathy
FSGS without presence of nephrotic syndrome‡	N02.1	Recurrent and persistent hematuria with focal and segmental glomerular lesions
	N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions
	N05.1	Unspecified nephritic syndrome with focal and segmental glomerular lesions
	N06.1	Isolated proteinuria with focal and segmental glomerular lesions
	N07.1	Hereditary nephropathy, not elsewhere classified with focal and segmental glomerular lesions

‡Presence of nephrotic syndrome includes proteinuria >3.5 g/24h (adults) or UPCR >2.0 g/g (pediatric patients <18 years of age), serum albumin <3.0 g/dL, and edema.¹

2 ways to submit the Patient Start Form



Fax the form to
888-381-0625



Upload the completed form
at start.traveretotalcare.com



Fax/upload copies of the **front and back** of patient's prescription insurance cards with this start form

*By selecting QuickStart, I believe my patient is at risk of rapid disease progression and a delay in therapy could lead to a negative outcome. I authorize TC Script to provide up to 60 days supply of FILSPARI dispensed directly to the above-named patient at no cost, while I coordinate with the patient's insurance.

†The Bridge Program is available at no cost for eligible patients on therapy experiencing an interruption or a delay in coverage. For commercially insured patients to be eligible for Extended Bridge beyond 60 days, an appeal of any prior authorization denial must be made, with documentation submitted to Traver TotalCare®. Eligibility will be reverified for patients continuing into the following year and potentially at other times during program participation.

FSGS, focal segmental glomerulosclerosis; IgAN, immunoglobulin A nephropathy; PO, by mouth; QD, once a day; REMS, Risk Evaluation and Mitigation Strategy; UPCR, Urine Protein Creatinine Ratio.



PATIENT INFORMATION

► INDICATES REQUIRED FIELD

1 | PATIENT INFORMATION

► Patient Name (First, MI, Last)	► DOB ____ / ____ / ____	► Sex Assigned at Birth ☐ M ☐ F	
► Shipping Address	► City	► State	► ZIP
► Phone #	Email		
Preferred Language: ☐ English ☐ Spanish ☐ Mandarin ☐ Other _____			

2 | PATIENT INSURANCE INFORMATION

Does the patient have insurance? ☐ Yes ☐ No IF YES , fill out the information below or attach copies of front and back of prescription cards		
► Primary Insurance	► Rx Policy Phone #	
► Name of Insured (cardholder)	► Rx Member ID	
Rx Group ID	Rx BIN	Rx PCN

3 | PATIENT/LEGAL GUARDIAN CERTIFICATION AND AUTHORIZATION

By signing below, I confirm that I have read and understand the Authorization to Share Health Information and Patient Support on the back cover and agree to the terms.

► **Signature of Patient or Parent/Legal Guardian** (if patient is under 18 years of age)  Date: ____ / ____ / ____

Printed Name of Parent/Legal Guardian (if signing on patient's behalf) 

☐ I would like to opt-in for other programs and resources from Travele and its service providers and agree to the Opt-In for Other Resources terms on the back cover (optional).

4 | PRESCRIBER INFORMATION

► Full Prescriber Name	► Prescriber NPI		
► Address	► City	► State	► ZIP
► Practice Name	► Phone #	► Fax	
► Office Contact	Direct Line	Email	

5 | DIAGNOSTIC, CLINICAL, AND PRESCRIPTION INFORMATION

Will the patient discontinue an ACEi/ARB prior to starting FILSPARI as required? (if applicable) ☐ Yes ☐ No

Check the box for the appropriate ICD 10 code below

► Primary IgAN ☐ N02.B (recurrent and persistent IgAN)	► FSGS without presence of nephrotic syndrome ☐ N02.1 (recurrent and persistent hematuria) ☐ N03.1 (chronic nephritic syndrome) ☐ N05.1 (unspecified nephritic syndrome)	☐ N06.1 (isolated proteinuria) ☐ N07.1 (hereditary nephropathy)
☐ Other diagnosis (include ICD 10 code): _____		

► **Complete FILSPARI prescription below. Choose only one prescription. If applicable, select QuickStart/Bridge.**

IgAN Prescription (select one)	FSGS (>50 kg) Prescription (select one)	FSGS (≤50 kg) Prescription (select one)
☐ Days 1-14: One 200 mg PO QD x14 days, 14 tablets ☐ Days 15+: One 400 mg PO QD x30 days, 30 tablets ☐ One 200 mg PO QD x30 days, 30 tablets ☐ Other _____	☐ Days 1-14: One 400 mg PO QD x14 days, 14 tablets ☐ Days 15+: Two 400 mg PO QD x30 days, 60 tablets ☐ Other _____	☐ Days 1-14: One 200 mg PO QD x14 days, 14 tablets ☐ Days 15+: One 400 mg PO QD x30 days, 30 tablets ☐ Other _____
☐ QuickStart*/Bridge Rx†	☐ QuickStart*/Bridge Rx†	☐ QuickStart*/Bridge Rx†

6 | PRESCRIBER AUTHORIZATION (Handwritten signatures only; e-signatures and stamps not acceptable)

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Prescriber Signature (dispense as written) 	► Date: ____ / ____ / ____
Prescriber Signature (substitution permitted) 	► Date: ____ / ____ / ____

By signing above, I verify that my patient has provided a signed HIPAA Authorization that allows me to share protected health information with Travele TotalCare® for purposes of the Patient Support Program. I further verify the information and prescription provided in this FILSPARI® Start Form and Prescription is complete and accurate to the best of my knowledge. I certify that this medication is medically necessary for the patient. I understand that Travele Therapeutics, Inc. ("Travele") reserves the right at any time and for any reason, without notice, to modify this form or to modify or discontinue any services or assistance provided through Travele TotalCare®. I authorize Travele and its designated agents to use and discontinue any services or assistance provided through Travele TotalCare®. I authorize Travele and its designated agents to use and disclose health information as necessary to verify the accuracy of any information provided, to provide reimbursement services through Travele TotalCare® (as applicable) to assess my patient's eligibility for copay assistance and for quality and data assurance purposes. By providing my fax number to you, I am consenting to receive faxes from Travele and its designated agents regarding FILSPARI and the lab support program.

By signing this form, I further certify that the information provided in this form is accurate to the best of my knowledge and that the patient meets the eligibility requirements of any Travele TotalCare® selected above, including without limitation, the requirement that the patient be prescribed FILSPARI for an FDA-approved indication. I acknowledge and agree that I may not bill for medication dispensed under the QuickStart Program or Patient Assistance Program to any private or government payer or other third party and that I will adhere to the terms and conditions of the programs.

Authorization to Share Health Information and Patient Support

The Traverse TotalCare® Program ("Program") is a support program for patients by Traverse Therapeutics, Inc. ("Traverse"). Before signing, the patient and/or patient's authorized representative should review and understand the terms of this Authorization to Share Health Information and Patient Support ("Authorization"). If an authorized representative signs for the patient, please indicate the relationship to the patient.

I understand that the collection, use, and disclosure of the patient's health information are protected under law. Information contained in this FILSPARI® Start Form and Prescription, such as the patient's name, address, insurance, prescription, and medical information, may be "protected health information" ("PHI"). By signing this Authorization, the patient agrees to the collection, use, and disclosure of the patient's PHI as described below and authorizes their treating physician, healthcare provider, health insurer, or pharmacist ("Insurer and Treating Providers") to share such information with Traverse and the company or companies that help Traverse administer the Program's Support Services ("Services").

I understand that once PHI about the patient is released based on this Authorization, federal privacy laws may not prevent Traverse and company or companies who administer the Services from further disclosing the patient's information. However, I understand that such entities have agreed to use or disclose PHI they receive only for the purposes described in this Authorization or as required by law.

By signing this form, I authorize Traverse and the company or companies that help administer the Services, to do the following:

- Request and receive information from the patient's Insurer and Treating Providers necessary to investigate and resolve the patient's insurance coverage, coding, or reimbursement inquiry or to provide the reimbursement support service that I have requested. Information may include the patient's medical diagnosis, condition, and treatment (including prescription information), the patient's health insurance, name, address, and telephone number;
- Collect, use, and disclose any patient information, including patient name, contact information, information related to disease, diagnosis, and treatment, medical insurance information, some of which may be considered PHI or consumer health data as defined by applicable law, for the purpose of investigating and resolving the patient's insurance coverage, coding, or reimbursement inquiry or to administer the Services, including entering and maintaining the patient's information in a database;
- Disclose patient information as described above with Traverse's service providers, contractors, analytics service providers, and business partners, including our business partners who support our research, surveys, focus groups or interviews related to the patient's diagnosis and the effectiveness of the Program;
- Disclose patient information as described above to the patient's Insurer and Treating Providers as necessary to resolve the patient's insurance coverage, coding, or reimbursement inquiry. The patient authorizes their Insurer and Treating Providers to release PHI about the patient's prescribed medications and medical condition requested by Traverse and the company or companies that help Traverse administer the Services;

- Contact the patient's plan(s) about their insurance benefit, coverage status, and product administration (eg, prescription, dosing, refills);
- Provide financial assistance resources, including copay assistance or free drug programs if I meet program eligibility; and
- Contact the patient's Insurer, other potential funding sources, social workers, patient advocacy organizations, or patient assistance programs (eg, the Traverse TotalCare® Program) on the patient's behalf to determine if the patient may be eligible for health insurance coverage or other funds, and disclose to them PHI about the patient's prescribed medications and medical condition that has been provided by the patient or patient's authorized representative or patient's Insurer and Treating Providers.

I understand that I may decline to sign this Authorization, and that doing so will not affect the patient's ability to receive FILSPARI® (sparsentan) or obtain insurance or insurance coverage. This Authorization will expire in 10 years or a shorter period if required by state law. I understand that I may revoke or cancel it at any time by calling 833-345-7727 or by writing to Traverse TotalCare®, 2250 Perimeter Park Dr, Suite 300, Morrisville, NC 27560. I understand that I am entitled to receive a copy of this Authorization, upon request.

I further understand that revoking this Authorization will prohibit PHI disclosures after the date written revocation is received by the Program, except to the extent that action has been taken already on this Authorization. After I revoke this Authorization, the patient's PHI may be disclosed among Traverse and the company or companies that help Traverse administer the Services in order to maintain records of the patient's participation, but it will not be otherwise disclosed or used. Further information on Traverse's privacy practices can be found at <https://traverse.com/privacy/>.

I understand that the pharmacy who may administer some of the Services may receive payment from Traverse as the manufacturer in exchange for securely sharing the patient's PHI with companies who administer the Services.

Opt-In for Other Resources

By checking the box on page one, I additionally authorize Traverse and its service providers to contact me by mail, email, telephone, or alternative communication to discuss and receive marketing communications, invitations to participate in research, educational materials, treatment support services and patient engagement initiatives designed for people taking FILSPARI®, including nutritional support and counseling.

Power of Attorney documentation is required if an adult other than the patient signs. You may fax the documents to 888-381-0625 or call 833-345-7727 for further assistance.

NOTE: Enrollment cannot be processed without a valid signature.

References: 1. FILSPARI Prescribing Information. San Diego, CA: Traverse Therapeutics, Inc. 2. Centers for Medicare & Medicaid Services. ICD-10. Accessed April 10, 2026. <https://www.cms.gov/medicare/coding-billing/icd-10-codes>

Complete all fields and fax to 888-381-0625 or upload the form online at start.traveretotalcare.com

Do not fax patient medical records

**Call us at 1-833-FILSPARI
(1-833-345-7727),
Monday-Friday, 8 AM-9 PM ET**