Clinical Policy: Budesonide (Tarpeyo)

Reference Number: CP.PHAR.572
Effective Date: 03.01.22
Last Review Date: 08.26
Line of Business: Commercial, HIM/ICHRA, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Budesonide (Tarpeyo™) is a corticosteroid.

FDA Approved Indication(s)

Tarpeyo is indicated to reduce the loss of kidney function in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Tarpeyo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Immunoglobulin A Nephropathy (must meet all)**:**

1. Diagnosis of IgAN confirmed via kidney biopsy;
2. Provider attestation that secondary causes of IgAN have been ruled out (e.g., IgA vasculitis, liver cirrhosis, viral (hepatitis, human immunodeficiency virus [HIV]) and bacterial infection, inflammatory bowel disease, autoimmune disease such as lupus);
3. Prescribed by or in consultation with a nephrologist;
4. Age ≥ 18 years;
5. Documentation of both of the following (a and b):
   a. Proteinuria of ≥ 0.5 g/day or urine protein-to-creatinine ratio (UPCR) ≥ 0.8 g/g;
   b. Recent (within the last 30 days) eGFR ≥ 35 mL/min/1.73 m^2;
6. Member is currently receiving therapy with a renin-angiotensin system (RAS) (e.g., irbesartan, losartan, lisinopril, benazepril) inhibitor at up to maximally indicated doses for at least 12 weeks;
7. Tarpeyo is prescribed in combination with a RAS inhibitor;
8. Dose does not exceed 16 mg (4 capsules) per day for 9 months, followed by 8 mg (2 capsules) per day for two weeks.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Immunoglobulin A Nephropathy (must meet all):

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. Decrease in UPCR from baseline;
   b. Reduction of proteinuria as evidenced by a lower total urine protein per day from baseline;
3. Member has not received more than 38 weeks of treatment with Tarpeyo;
4. If request is for a dose increase, new dose does not exceed 16 mg (4 capsules) per day for 9 months, followed by 8 mg (2 capsules) per day for two weeks.

Approval duration: up to a total treatment duration 38 weeks*

** Treatment consists of 9 months of therapy followed by a 2-week dose taper (see Section V below)*

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ACEi: angiotensin converting enzyme inhibitor
ARB: angiotensin receptor blocker
eGFR: estimated glomerular filtration rate
FDA: Food and Drug Administration
IgAN: immunoglobulin A nephropathy
RAS: renin-angiotensin system
UPCR: urine protein-to-creatinine ratio

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Maximum Dose
RAS inhibitors	
Angiotensin-converting enzyme (ACE) inhibitors (e.g., benazepril, captopril, enalapril, lisinopril, quinapril)	Varies
Angiotensin-receptor blockers (ARB) (e.g., candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan)	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to budesonide or any ingredients in Tarpeyo
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
IgAN	16 mg PO QD for 9 months. When discontinuing therapy, reduce dose to 8 mg PO QD for the last 2 weeks of therapy.	See dosing regimen

VI. Product Availability

Delayed release capsule: 4 mg

VII. References

1. Tarpeyo Prescribing Information. Calliditas Therapeutics AB; Stockholm, Sweden: June 2024. Available at: www.tarpeyo.com. Accessed May 7, 2026.
2. Kidney Disease: Improving Global Outcomes (KDIGO) 2025 Clinical Practice Guideline for the Management of Immunoglobulin A Nephropathy (IgAN) and Immunoglobulin A Vasculitis (IgAV). Kidney International (2025)108(Suppl 4S), S1–S71. Available at: https://kdigo.org/wp-content/uploads/2024/08/KDIGO-2025-IgAN-IgAV-Guideline.pdf.
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. Available at: https://kdigo.org/wp-content/uploads/2017/02/KDIGO-Glomerular-Diseases-Guideline-2021-English.pdf.
4. Fellström BC, Barratt J, Cook H, et al. NEFIGAN Trial Investigators. Targeted-release budesonide versus placebo in patients with IgA nephropathy (NEFIGAN): a double-blind, randomised, placebo-controlled phase 2b trial. Lancet. 2017 May 27;389(10084):2117-2127.
5. Lv J, Zhang H, Wong MG, et al. Effect of oral methylprednisolone on clinical outcomes in patients with iga nephropathy: The TESTING randomized clinical trial. JAMA 2017; 318:432.
6. Manno C, Torres DD, Rossini M, et al. Randomized controlled clinical trial of corticosteroids plus ACE-inhibitors with long-term follow-up in proteinuric IgA nephropathy. Nephrol Dial Transplant 2009; 24:3694.
7. Lv J, Zhang H, Chen Y, et al. Combination therapy of prednisone and ACE inhibitor versus ACE-inhibitor therapy alone in patients with IgA nephropathy: A randomized controlled trial. Am J Kidney Dis 2009; 53:26.
8. Rauen T, Eitner F, Fitzner C, et al. Intensive supportive care plus immunosuppression in IgA nephropathy. N Engl J Med 2015; 373:2225.
9. Pozzi C, Bolasco PG, Fogazzi GB, et al. Corticosteroids in IgA nephropathy: A randomised controlled trial. Lancet 1999; 353:883.
10. Barratt J, Lafayette R, Kristensen J, et al. Results from part A of the multi-center, double-blind, randomized, placebo-controlled NefIgArd trial evaluated targeted-release formulation of budesonide for the treatment of primary immunoglobulin A nephropathy. Kidney Int. 2022 Oct 18: S0085-2538(22)00836-5.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications and continued therapy section.	10.07.22	
1Q 2023 annual review: per clinical trial inclusion criteria added the following requirement: Recent (within the last 30 days) eGFR ≥ 35 mL/min/1.73 m^2; references reviewed and updated.	10.27.22	02.23
1Q 2024 annual review: no significant changes; clarified 1 g/day is associated with proteinuria rather than UPCR; for continuation of therapy revised approval duration from 6 months to "up to a total treatment duration 38 weeks"; references reviewed and updated. RT4: updated FDA approved indication per updated prescribing information following conversion from accelerated to regular approval.	01.02.24	02.24

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Revise redirection to require one alternative systemic corticosteroid.	05.07.24	08.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	11.20.24	02.25
1Q 2026 annual review: removed requirement of one alternative systemic corticosteroid and revised criterion for proteinuria ≥ 0.5 g/day per updated KDIGO 2025 guidance; references reviewed and updated.	10.21.25	02.26
3Q 2026 annual review: added ICHRA line of business; for initial approval criteria, clarified ACEi/ARB for 90 days to RAS inhibitor for 12 weeks, clarified confirmation requirement to documentation; for continued therapy, added reduction of proteinuria by lower total urine protein per day from baseline as evidence of positive response to therapy; references reviewed and updated.	05.07.26	08.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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