Tavneos (avacopan)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Granulomatosis with Polyangiitis (GPA)/Microscopic Polyangiitis ☐ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is this medication being used in conjunction with a clinical trial? ☐ Yes ☐ No

Has the patient been screened for Hepatitis B virus (HBV) infection prior to initiating therapy? ☐ Yes ☐ No

Has the physician assessed disease severity utilizing an objective measure/tool (i.e., Birmingham Vasculitis Activity Score [BVAS])? ☐ Yes ☐ No *Provide detailed documentation that includes evidence of the below*

- **Baseline score of at least 16 with one of the following:**
  1. **patient has 1 major item; OR**
  2. **patient has at least 3 non-major items; OR**
  3. **patient has at least 2 renal items of proteinuria and hematuria.**

For <u>Granulomatosis with Polyangiitis (GPA)/Microscopic Polyangiitis</u> answer the following:

Does the patient have a diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA)? ☐ Yes ☐ No

Does the patient have severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis that is GPA or MPA only? ☐ Yes ☐ No *Provide detailed documentation*

Does patient have autoantibodies for proteinase 3 (PR3) or myeloperoxidase (MPO) as detected using indirect immunofluorescence (IIF) assay or antigen-specific enzyme-linked immunosorbent assays (ELISAs)?
☐ Yes ☐ No *Must provide lab value documentation*

Is the patient's disease confirmed by tissue biopsy at the site of active disease? ☐ Yes ☐ No *Must provide lab value documentation.*

Will the requested medication be used as adjunctive therapy in combination with standard therapy (e.g., corticosteroids, cyclophosphamide, azathioprine, mycophenolate, rituximab, etc.)?
☐ Yes ☐ No *Provide name of drugs and dosage*

Has the patient failed one of the following below regimens during <u>induction</u> <u>OR</u> both regimens during <u>maintenance</u>? ☐ Yes ☐ No *Provide name of drugs, dates and dosage*

1. **Immunosuppressant therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate, etc.)**
2. **Anti-CD monoclonal antibody therapy (i.e., rituximab)**

<u>For renewal, please answer the following:</u>

Has the patient had disease response from pre-treatment baseline as indicated by the following?

1. **Absence of new symptoms** □ **Yes** □ **No** ***Provide chart note documentation***
2. **Minimal glucocorticoid requirement** ***Provide drug, dates and dosage***

Does the patient have disease response by one or more of the following? □ **Yes** □ **No** ***Provide detailed chart note and/or lab documentation***

1. **Decrease in relapses/flares and/or ANCA levels**
2. **Improvement in organ manifestations**
3. **Remission [defined as a composite scoring index of 0 on the BVAS]**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811