HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
TAVNEOS®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tavneos® (avacopan)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SEVERE ANTINEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULTIS (AAV)			
1. Is the member ≥ 18 years of age?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a rheumatologist?	☐	☐	**Please provide documentation**
3. Does the member have a diagnosis of either of the following: • Active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (AAV) due to granulomatosis with polyangiitis (GPA); or • Microscopic polyangiitis (MPA)	☐	☐	**Please provide documentation**
4. Does documentation show positive anti-proteinase 3 (PR3) or anti-myeloperoxidase (MPO) ANCA-associated vasculitis?	☐	☐	**Please provide documentation**
5. Does the member have a current eGFR ≥ 15 mL/min/1.73m^2?	☐	☐	**Please provide documentation**
6. Does the member currently require dialysis or have a kidney transplant, and has received plasma exchange in the past 12 weeks?	☐	☐	**Please provide documentation**
7. Does the member have a baseline Birmingham Vasculitis Activity Score (BVAS; version 3) with either of the following: • At least one or more major items • At least three or more non-major items • At least two renal items of hematuria and proteinuria	☐	☐	**Please provide documentation**

8. Has the member had at least a 3-month trial and failure of glucocorticoid therapy at the maximally indicated doses, unless contraindicated or a clinically significant intolerance is experienced?	☐	☐	**Please provide documentation**
9. Does documentation show concurrent therapy with cyclophosphamide or rituximab?	☐	☐	**Please provide documentation**
10. Does documentation show baseline Hepatitis B (HBV) prior to initiating therapy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the member shown a ≥ 50% reduction of BVAS score from baseline?	☐	☐	**Please provide documentation**
3. Does documentation show continued liver function monitoring performed by the provider?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-132
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date: 03/16/2024
Current Effective Date: 07/01/2024

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