**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Tavneos (avacopan) Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 6 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tavneos (avacopan)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Provider Information**

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

**Clinical Criteria:**

1. Is this medication being prescribed by, or in consultation with, a Rheumatologist, Nephrologist, or Pulmonologist?
   □ No □ Yes

2. Is the patient ≥18 years of age?
   □ No □ Yes

3. Does the patient have a diagnosis of anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis [granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)]?
   □ No □ Yes

4. Is there a positive test for anti-PR3 (proteinase 3) or anti-MPO (myeloperoxidase) antibodies OR positive tissue biopsy?
   □ No □ Yes

5. Does the patient have history of significant intolerance to steroid or relative contraindication to steroid per prescriber judgement (factoring in comorbidities and other clinical considerations) OR requires a decrease in cumulative steroid dose due to steroid-induced complications?
   □ No □ Yes

6. Does the patient have ANY of the following conditions (therapy will not be approved if so)?
   - Eosinophilic granulomatosis with polyangiitis (EGPA)
   - Active, untreated and/or uncontrolled chronic liver disease and cirrhosis [especially those with hepatic impairment (Child-Pugh C) and including hepatitis B and hepatitis C]
   - Active serious infection, including localized infections
   - Pregnant or breast-feeding

   □ No □ Yes

**For continuation of therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.**

1. Is there documentation of positive clinical response?
   □ No □ Yes

2. Does the patient have any of the conditions as noted in initial review criteria (renewal will not be approved if so)?
   □ No □ Yes

3. Has there been an office visit or telephone visit with a specialist within the past 12 months?
   □ No □ Yes

**6 – Provider Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Provider Signature:** | **Date:** |
|---|---|
| | |