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- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Tavneos (avacopan)** for **VA 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 the patient ≥18 years of age?
   □ No □ Yes

2. Does the patient have severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis AND at least ONE of the following?
   - Autoantibodies for proteinase 3 (PR3) or myeloperoxidase (MPO), as detected using indirect immunofluorescence (IIF) assay or antigen-specific enzyme-linked immunosorbent assays (ELISAs), OR
   - Confirmation of disease by tissue biopsy at the site of active disease

   □ No □ Yes

3. Has the patient been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment, and will be monitored and followed for reactivation of hepatitis B?
   □ No □ Yes

4. Has the physician assessed disease severity utilizing an objective measure/tool [e.g., Birmingham Vasculitis Activity Score (BVAS)] AND has a baseline score of ≥16 with one of the following:
   - 1 major item, OR
   - ≥3 non-major items, OR
   - ≥2 renal items of proteinuria and hematuria

   □ No □ Yes

5. Does the patient have ANY of the following (therapy will not be approved if so)?
   - Active infections, including clinically important localized infections
   - Severe hepatic impairment (e.g., Child-Pugh C) or active, untreated, and/or uncontrolled chronic liver disease (e.g., chronic active hepatitis B, untreated hepatitis C, uncontrolled autoimmune hepatitis, cirrhosis)

   □ No □ Yes

6. Will the patient avoid concomitant therapy with strong and moderate CYP3A4 inducers (e.g., rifampin, carbamazepine, St. John's Wort)?
   □ No □ Yes

7. Will the patient avoid concomitant therapy with CYP3A4 inhibitors (e.g., ketoconazole, itraconazole), OR if therapy is unavoidable, patient will be monitored closely for adverse reactions and/or dose modifications will be implemented?
   □ No □ Yes

8. Has the patient had failure on ONE of the following regimens (if failure occurred during induction), OR failed on BOTH of the following regimens (if failure occurred during maintenance), unless contraindicated or not tolerated *(Note: may be used with or without glucocorticoids):*
   - Immunosuppressant therapy (e.g., cyclophosphamide, azathioprine, methotrexate, mycophenolate)
   - Anti-CD20 monoclonal antibody therapy (e.g., rituximab)

   □ No □ Yes

9. Will Tavneos be used as adjunctive therapy in combination with standard therapy (e.g., corticosteroids, cyclophosphamide, azathioprine, mycophenolate, rituximab)?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below.

1. Does the patient continue to meet the above initial criteria?
   □ No □ Yes

2. Has the patient experienced disease response from pre-treatment baseline, as indicated by ALL of the following?

- Absence of disease symptoms
- Minimal glucocorticoid requirement (e.g., <5 mg of prednisone or equivalent)
- ≥1 of the following:
    i. Decrease in relapses/flares and/or ANCA levels, OR
    ii. Improvement in organ manifestations (e.g., those with pulmonary-renal syndrome should improve in PFTs, proteinuria, creatinine), OR
    iii. Remission (defined as a composite scoring index of 0 on the BVAS)

□ 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:**