TRICARE Prior Authorization Request Form for avacopan **(Tavneos)**

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HEALTH PLANS
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Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization of initial therapy is for 6 months. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Tavneos.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **5**
2. Has the patient responded positively to therapy as evidenced by a reduction in symptoms or remission?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the request for a dose increase?	☐ Yes Proceed to question **4**	☐ No **Sign and date below**
4. Does the new dose exceed 60 mg (2 tabs) per day?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
5. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the requested medication prescribed by or in consultation with a rheumatologist?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Does the patient have a documented diagnosis of granulomatosis with polyangiitis (GPA) (Wegener's), microscopic polyangiitis (MPA)? Note: Non FDA approved used are not approved including Immunoglobulin A nephropathy, Hidradenitis suppurativa, acne inversa, and C3 Glomerulopathy (C3G).	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a positive ELISA test for anti-proteinase-3 (PR-3)?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Does the patient have a positive ELISA test for anti-myeloperoxidase (MPO)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient experienced or has a high probability to experience significant adverse effect from prednisone?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the requested medication prescribed in combination with cyclophosphamide or rituximab, unless clinically significant adverse effects are experienced or both are contraindicated?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

_____ _____
Prescriber Signature Date

[03 January 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: