Prescriber Criteria Form

Tavneos 2025 PA Fax 5032-A v1 010125.docx
Tavneos (avacopan)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Tavneos (avacopan).

Drug Name:
Tavneos (avacopan)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient been diagnosed with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA])? [If no, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed as adjunctive treatment in combination with standard therapy? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient currently receiving therapy with the requested medication? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced benefit from therapy?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____