PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 6/13/2025
Patient ID: _____ **Patient Date Of Birth:**
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?

   Severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) (If checked, go to 2) ☐

   Other, please specify (If checked, no further questions) ☐

   _____

2. Is the patient currently receiving Tavneos? **Y** ☐ **N** ☐

3. Has the patient achieved or maintained a positive clinical response as evidenced by stabilization or improvement in the most impactful aspects of the patient's ANCA-associated vasculitis (e.g., renal, pulmonary, neurologic)? ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record(s) showing stabilization or improvement in the most impactful aspects of the patient's ANCA-associated vasculitis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

4. Will Tavneos be used in combination with standard therapy (e.g., rituximab, cyclophosphamide, methotrexate, azathioprine, mycophenolate mofetil)? **Y** ☐ **N** ☐

5. Does the patient have a history of testing positive for the anti-proteinase-3 (anti-PR3) or anti-myeloperoxidase (anti-MPO) antibody? ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record(s) showing positive serum assay for anti-PR3 or anti-MPO.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

6. Is there documentation of pretreatment objective assessment of the most impactful aspects of the patient's ANCA-associated vasculitis (e.g., renal, pulmonary, neurologic)? ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record(s) showing the most impactful aspects of the patient's ANCA-associated vasculitis.
   ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date