TAVNEOS™ (avacopan) Start Form

TAVNEOS™ connect

Instructions for HCP:

For all patient referrals, please complete Sections 1-5 of this form and any other applicable sections.

Sign and date relevant section(s). Section 8 is required.

Fax completed Start Form to TAVNEOS Connect. Fax: 1-833-200-7366

1 PRESCRIBER INFORMATION

Prescriber Name _____ Designation _____ NPI # _____ Specialty _____

Clinic/Facility _____ Office Contact _____ Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

2 PATIENT INFORMATION AND CONSENT

Patient Full Name _____ Date of Birth ___/___/___ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____ Primary Phone _____

Mobile Phone (if different) _____ Email _____

Alternate Authorized Contact (if applicable) _____ Phone _____ Relationship _____

By signing here, I am providing program authorization as outlined in Section 9 on page 2 ***OR*** ☐ Please contact my patient to offer eSignature consent

Signature for Consent _____ Date ___/___/___

Indicate if signed by ☐ **Patient** or by ☐ **Authorized Contact**

3 INSURANCE INFORMATION

Please check the appropriate box: Does the patient have insurance? ☐ Yes ☐ No **If yes, CHOOSE ONE:**

Please provide a copy of the patient's insurance card(s). **or** Please complete the information below if there is insurance and you do NOT have the patient's insurance card.

Prescription Drug Insurance Plan:

Rx Insurance Provider _____ Rx Insurance Phone _____ Patient's Member ID # _____

Policyholder Name (if different from patient) _____ Policyholder Date of Birth ___/___/___ Relationship to Patient _____

4 CLINICAL INFORMATION

Diagnosis Code (please make appropriate choice below)

☐ M31.3	Granulomatosis with polyangiitis (GPA)*	☐ M31.30	Granulomatosis with polyangiitis (GPA)* without renal involvement	☐ Other ICD-10 Code _____
☐ M31.31	Granulomatosis with polyangiitis (GPA)* with renal involvement	☐ M31.7	Microscopic polyangiitis (MPA)	Description _____

*Formerly known as Wegener's granulomatosis.

Current Medication(s) (please list below)

_____

Please include relevant chart notes and/or laboratory results.

5 PRESCRIPTION (Rx)

If your state law requires, or you prefer to submit a separate Rx, please indicate that here and submit via the appropriate method.†

☐ Separate Rx attached ☐ Separate Rx submitted electronically to ARx Patient Solutions Pharmacy (see eRx info at the bottom of page 2)

If not submitting a separate Rx, please complete all fields below and sign.

Patient Name _____ Date of Birth ___/___/___

Medication _____ Strength _____ Quantity _____

Directions for Use _____ Refills _____

Prescriber Signature _____ Date ___/___/___

Specialty Pharmacy Preference (subject to insurance requirements)**:** ☐ Amber Specialty Pharmacy ☐ PANTHERx Rare ☐ No preference

†*The information contained in this document will become a legal prescription. Follow all state Medical Board guidelines when completing or submit a separate prescription if necessary.*

Provide all information on this form unless it is not applicable. For assistance completing this form, please call TAVNEOS Connect at 1-833-TAVNEOS (828-6367), Option 2, Monday through Friday (8 AM to 8 PM ET).

Visit www.tavneos.com for Full Prescribing Information and Medication Guide for TAVNEOS.

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6 QUICK START PROGRAM REFERRAL Only complete if requesting Quick Start Program enrollment

This program offers a 30-day supply of TAVNEOS to eligible patients whose insurance plan requires an authorization and whose HCP believes a delay in therapy could lead to negative clinical outcomes.

☐ By checking this box, I authorize ARx Patient Solutions Pharmacy to dispense a 30-day supply of the Rx written on this form, attached, or provided electronically.

7 HOSPITAL-TO-HOME PROGRAM REFERRAL Only complete if requesting Hospital-to-Home Program enrollment

This program provides a 30-day supply of TAVNEOS for eligible patients being discharged from an inpatient setting to support continuity of care. Patients currently taking TAVNEOS in an outpatient setting are not eligible for this program.

Date of Admission ____/____/____ Date of Discharge (anticipated) ____/____/____

Was the patient on TAVNEOS therapy at time of inpatient admission? ☐ Yes ☐ No Was TAVNEOS treatment newly initiated in the inpatient setting? ☐ Yes ☐ No

Follow-up with outpatient HCP scheduled? ☐ Yes ☐ No

Outpatient Managing HCP _____ Phone _____

☐ By checking this box, I authorize ARx Patient Solutions Pharmacy to dispense a 30-day supply of the Rx written on this form, attached, or provided electronically.

If approved, medication will be shipped to patient via overnight delivery. This completed Start Form must be received by 12 PM ET for the pharmacy to process the Rx and contact the patient for shipment in order to ship for next-day delivery to the patient's residence (not including holidays or weekends).

8 HCP ATTESTATION & AUTHORIZATION

As the undersigned Prescriber, or the Prescriber's Designated Agent, I certify that the information provided for enrollment is complete and accurate to the best of my knowledge and that treatment with TAVNEOS is medically necessary. I certify that I have obtained the patient's authorization to use and disclose their protected health information (PHI), as required by HIPAA, to the respective agents and service providers of ChemoCentryx, Inc. (CCXI) who, in turn, may use and disclose the patient's PHI to respective agents and designees of: (1) other healthcare providers involved in the patient's treatment; and (2) the patient's health plans or insurers for the purposes of care coordination related to their treatment with TAVNEOS. In support of my patient, I authorize CCXI to conduct the following related to TAVNEOS: benefits eligibility; reimbursement support; CCXI copay program enrollment, if eligible; and coordination and dispensing of TAVNEOS by a network pharmacy, including obtaining information related to patient support matters from that pharmacy. I authorize CCXI to contact the patient or their representative regarding: providing program consent; application to any CCXI patient support program(s) for which they may be eligible; any necessary signatures or information related to these programs and/or care coordination associated with their TAVNEOS treatment. I agree that I may be contacted for additional information as needed related to the patient's TAVNEOS treatment and/or coordination of care. If the undersigned is a "Designated Agent", such person is duly authorized by the Prescriber to sign this "Healthcare Provider Authorization" on the Prescriber's behalf, in accordance with applicable law and medical standards. I certify that I have reviewed the additional terms available at https://ebvterms.com/terms, which are specifically incorporated herein by reference, and acknowledge and consent to their application and enforceability in regards to this certification.

Signature of Prescriber or Designated Agent _____ Date ____/____/____

Name/Title if Designated Agent _____

Please fax completed Start Form to TAVNEOS Connect. Fax: 1-833-200-7366. For questions, please call 1-833-TAVNEOS (1-833-828-6367), Option 2.
If e-prescribing, send eRx to: ARx Patient Solutions Pharmacy 4500 W. 107th Street Overland Park, KS 66207 NCPDP: 1720677.

Provide all information on this form unless it is not applicable. For assistance completing this form, please call TAVNEOS Connect at 1-833-TAVNEOS (828-6367), Option 2, Monday through Friday (8 AM to 8 PM ET).

Visit www.tavneos.com for Full Prescribing Information and Medication Guide for TAVNEOS.

Please tear here

Please note: Patient consent language can be provided to patient, if desired

9 PATIENT CONSENT AND AUTHORIZATION (OPTIONAL)

TAVNEOS Connect is a program administered by ChemoCentryx, Inc. (CCXI) that provides patient support to eligible patients who have been prescribed TAVNEOS™ (avacopan). By signing this form, I authorize my healthcare professionals, including my physicians, pharmacies and my health insurance plan, to share my personally identifiable medical and insurance information ("my information") with the respective agents and service providers of CCXI so that CCXI can: help facilitate my access to TAVNEOS through the patient support program; contact me, based on my preferences, via phone (including voicemail), email, mail or text to provide me with information, education and resources, including ways to help me maintain my prescribed treatment; communicate assistance programs and support I may be eligible for related to my medical condition and treatment with TAVNEOS; administer and analyze the effectiveness of TAVNEOS Connect; carry out other business purposes related to TAVNEOS; and comply with law. I understand and agree that my pharmacies may receive remuneration from CCXI in exchange for sharing my information or providing support services to me. Once my information has been shared with CCXI, federal privacy laws may no longer protect the information. However, CCXI agrees to protect my information by using and disclosing it only for purposes described in this authorization. I understand that if I do not sign this form, I will still be eligible for my health plan benefits and that my treatment and payment for my treatment will not be affected, but I will not have access to all the CCXI services and support described herein. I may cancel or revoke this authorization at any time by mailing a letter to TAVNEOS Connect at 4700 Millenia Blvd., Suite 500, Orlando, FL, 32839 or calling the program at 1-833-828-6367, option 2. Normal carrier charges may apply to text messages; opt out of texting at any time by responding STOP. This authorization expires 5 years from the date signed, or earlier if required by state or local law, unless I revoke it before then. I understand I am entitled to and may request a copy of my signed authorization. By signing, I confirm that I would like to opt in to TAVNEOS Connect so that CCXI can provide me with patient support.

Visit www.tavneos.com for Full Prescribing Information and Medication Guide for TAVNEOS.

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ChemoCentryx

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