TAVNEOS® (avacopan) capsules 10mg

START FORM

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 this completed Start form (with Rx) to ***ONLY ONE*** of the available options.

	For QUICK START or HOSPITAL-TO-HOME	SPECIALTY PHARMACIES	
	TAVNEOS connect		
	Patient Support Hub Team	Amber Specialty Pharmacy	PANTHERx Rare Pharmacy
Fax:	1-833-200-7366	1-402-896-3774	1-866-312-4206
ePrescribe to:	ARx Patient Solutions	Amber Specialty Pharmacy	Pantherx Specialty Pharmacy
Address:	4500 W. 107th St. Overland Park, KS 66207	10004 South 152nd St. Omaha, NE 68138	24 Summit Park Dr. Pittsburgh, PA 15275
NCPDP #:	1720677	2815338	3997117

1 PRESCRIBER INFORMATION

Prescriber Name _____ Designation _____ NPI # _____ Specialty _____

Clinic/Facility _____ Contact Name _____ Contact's 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 _____ OK to leave VM? ❑ Yes ❑ No Mobile Phone (if different) _____ OK to leave VM? ❑ Yes ❑ No

Email _____ OK to email? ❑ Yes ❑ No

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 _____ Signed by ❑ **Patient** or by ❑ **Authorized Contact**

3 INSURANCE INFORMATION

Does the patient have insurance? ❑ Yes ❑ No **If 'No', complete form and submit to TAVNEOS Connect Hub Team directly** (Fax: 1-833-200-7366).

Please complete the information below if there is insurance and you do NOT have the patient's insurance card.

or

Please provide a copy of the patient's insurance card(s).

Prescription Drug Insurance Plan:

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

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	❑ I77.6	Unspecified Arteritis**
❑ M31.31	Granulomatosis with polyangiitis (GPA)* with renal involvement	❑ M31.7	Microscopic polyangiitis (MPA)		
❑ Other	ICD-10 Code _____	Description (required) _____			

Unspecified Arteritis: **The diagnosis is related to ANCA Associated Vasculitis or MPA/GPA, specifically; and confirmed or awaiting confirmation using one or more lab tests: ANCA serum/biopsy/urinalysis

*GPA is formerly known as Wegener's granulomatosis.

PLEASE INCLUDE RELEVANT CHART NOTES AND/OR LABORATORY RESULTS

Current Medication(s) (please list below)

_____

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 (*eRx info at top of page associated with your submission choice*)

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

Patient Name _____ Date of Birth _____

Medication *TAVNEOS® (avacopan)* Strength *10 mg* Quantity *180*

Directions for Use *Take three (3) capsules by mouth twice daily with food* Refills _____

Prescriber Signature _____ **Date** _____

If sending to TAVNEOS Connect Hub Team, select your 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, then Option 1.
Visit www.tavneos.com for Full Prescribing Information and Medication Guide for TAVNEOS.

TAVNEOS® (avacopan) capsules 10mg START FORM

For QUICK START or HOSPITAL-TO-HOME, submit only to TAVNEOS Connect Hub Team
Fax: 1-833-200-7366 **ePrescribe to:** ARx Patient Solutions
Address: 4500 W. 107th St. Overland Park, KS 66207 **NCPDP #:** 1720677

TAVNEOS® connect

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

This program initially provides up to 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 initially provides up to a 30-day supply of TAVNEOS to 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.

Inpatient Facility Name _____ Contact Name _____ Contact's Phone _____

Date of Admission _____ Was the patient on TAVNEOS therapy at time of admission? ❑ Yes ❑ No

Was TAVNEOS newly initiated and administered in the inpatient setting? ❑ Yes ❑ No Date of Discharge (anticipated) _____

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, the pharmacy must speak with the patient before dispensing and shipping. To increase the likelihood of shipping the same day of receipt - **this form must be received by 12 pm ET** to process the referral and contact the patient to set up 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 _____

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, then Option 1.
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 PO Box 592188, Orlando, FL 32859-2188 or calling the program at 1-833-828-6367, Option 2, then Option 1. 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 above, 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.

ChemoCentryx, Inc.
835 Industrial Road, Suite 600, San Carlos, CA 94070