

Faxing the TAVNEOS® Start Form to the TAVNEOS® Connect Team is an easy way to get your patients started with treatment and enroll appropriate patients in the Quick Start Program.

✓ To expedite the onboarding process, **use dark ink and complete all required fields**. Incomplete or illegible information will require outreach by the TAVNEOS® Connect Team and may cause delays

A Fax to the TAVNEOS® Connect Team at 1-833-200-7366

B Provide key office contact and direct number. Please ensure key contacts are reachable via phone to work with the TAVNEOS® Connect Team and share required information

TAVNEOS® (avacopan) START FORM

Instructions for HCP:

- For all patient referrals, please complete sections 1-5 of this form (if requesting Quick Start, please also complete section 6).
- Sign & date Rx (section 5) or submit eRx.
- Fax this completed Start Form to **ONLY ONE** of the available options.

TAVNEOS connect		SPECIALTY PHARMACIES	
A Patient Support Team Fax: 1-833-200-7366 ePrescribe to: ARx Patient Solutions Address: 4500 W. 107th St. Overland Park, KS 66207 NCPDP #: 1720677		B Amber Specialty Pharmacy 1-802-896-3774 Amber Specialty Pharmacy 1000 South 152nd St. Omaha, NE 68138 2815338	C PANTHERx Rare Pharmacy 1-866-312-4206 PANTHERx Specialty Pharmacy 24 Summit Park Dr. Pittsburgh, PA 15275 3997117

1. PRESCRIBER INFORMATION

Prescriber Name _____ 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 Preferred language _____
 Alternate Authorized Contact (if applicable) _____ Phone _____ Relationship _____
 By signing here, I am providing program authorization as outlined in Section 8 on page 2 OR ☐ Please contact my patient to offer eSignature or verbal consent

Signature for Patient 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 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)

<input type="checkbox"/> I77.82 ANCA associated vasculitis, ANCA positive vasculitis (GPA or MPA)	<input type="checkbox"/> I77.6 Unspecified Arteritis*
<input type="checkbox"/> M31.3 Granulomatosis with polyangiitis (GPA)	<input type="checkbox"/> M31.30 Granulomatosis with polyangiitis (GPA) without renal involvement
<input type="checkbox"/> M31.31 Granulomatosis with polyangiitis (GPA) with renal involvement	<input type="checkbox"/> M31.7 Microscopic polyangiitis (MPA)
<input type="checkbox"/> Other ICD-10 Code Description (required) _____	

*GPA is formerly known as Wegener's granulomatosis.

Current Medication(s) _____

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 Team, select your Specialty Pharmacy Preference (to reflect 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 extension 1. Please see full Prescribing Information and Medication Guide for TAVNEOS.

C If your patient has an authorized contact for healthcare-related communications, be sure to provide their name, relationship to the patient, and contact information. **The patient or their authorized contact may be contacted to provide patient consent and program authorization if the signature is not provided on the form**

D Ask the patient or their authorized contact to review the consent language on page 2 and provide their signature and date

E TAVNEOS® is covered under the pharmacy benefit of many insurance plans. Be sure to provide the patient's "pharmacy" or "prescription drug" insurance plan. Patients without pharmacy or prescription drug insurance coverage may be eligible for the TAVNEOS® Patient Assistance Program

F Select the appropriate diagnosis code

G The information in the Start Form will become a legal prescription if Section 5 is filled out. Follow all relevant medical guidelines when completing or submit a separate prescription to ARx Patient Solutions, if necessary

H Ensure prescriber signature is provided

I The TAVNEOS® Connect Team will triage the script to the mandated or preferred Specialty Pharmacy



Visit tavneospro.com/tavneos-connect to download the Start Form or ask your Amgen representative

Completing the Start Form (cont'd)

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Check this box if you wish to enroll your patient in the TAVNEOS® Connect Quick Start Program, **whether they will begin TAVNEOS® in an inpatient or outpatient setting**. The program provides up to a **30-day supply for eligible patients***

- Whose insurance plan requires a PA and you believe a delay in therapy could lead to negative clinical outcomes
- Who are discharged from an inpatient setting to support continuity of care

TAVNEOS® (avacopan) capsules 10mg START FORM

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

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.
 This program can also provide up to a 30-day initial supply of TAVNEOS to eligible patients being discharged from an inpatient setting to support continuity of care.
☐ By checking this box, I authorize AssistRx Patient Solutions to dispense, using a copy of the Rx written on this form, attached, or provided electronically, per program business rules.

For patients starting TAVNEOS in a hospital setting:

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 _____
If patient is approved for Quick Start, 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).
 Please alert your patient that upon program approval the pharmacy will call the patient to confirm shipping.

7 HCP ATTESTATION & AUTHORIZATION
 By completing and faxing this form, you represent that your patient is aware of the disclosure of their personal health information to Amgen and its agents for Amgen's patient support services, including reimbursement and verification services and the services provided by field reimbursement professionals in your office, as part of the patient's treatment with this product and that you have obtained appropriate patient authorizations as needed.

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.
 Please see full Prescribing Information and Medication Guide for TAVNEOS.

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 USA-569-80050 04/23

Please note: A copy of this patient consent language can be provided to patient, if desired.

8 PATIENT CONSENT AND AUTHORIZATION (OPTIONAL)
 TAVNEOS Connect is a program administered by ChemoCentryx, Inc. (together with its parent company Amgen Inc., "CCOI") 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 CCOI so that CCOI 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 CCOI in exchange for sharing my information or providing support services to me. Once my information has been shared with CCOI, federal privacy laws may no longer protect the information. However, CCOI 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 CCOI 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 CCOI can provide me with patient support.

Please see full Prescribing Information and Medication Guide for TAVNEOS.

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 www.amgen.com

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If your patient started TAVNEOS® in an inpatient hospital setting and is transitioning to outpatient therapy, fill out this section. **Be sure to include the outpatient managing HCP's information**

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Fax the Start Form and the TAVNEOS® Connect Team will process the enrollment and coordinate shipment as soon as possible. **Please alert your patient or their authorized contact that they will receive a call from the pharmacy to coordinate TAVNEOS® shipment**

For questions, call the TAVNEOS® Connect Team at 1-833-TAVNEOS (1-833-828-6367) and choose option 2, Monday through Friday from 8 AM to 8 PM ET

*TAVNEOS® Connect services are available for patients whose diagnosis is aligned with the FDA-approved indication for TAVNEOS®. Additional eligibility criteria may apply.

FDA=US Food and Drug Administration; HCP=healthcare provider; PA=prior authorization.



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