TAVNEOS® (avacopan)

PATIENT ENROLLMENT FORM

Instructions for HCP:

- Complete all sections of this form (Section 4 needs to be completed only if Quick Start is being requested). An incomplete form submission may delay the start of treatment.
- Sign & date Rx or submit eRx.
- Choose ONE TAVNEOS® Specialty Pharmacy from the list and fax this completed Patient Enrollment Form

CHOOSE ONE
TAVNEOS® SPECIALTY PHARMACY

	Biologics By McKesson		PANTHERx Rare Pharmacy
Fax:	**1-800-823-4506**	OR	**1-866-312-4206**
ePrescribe to:	Biologics		PANTHERx Specialty Pharmacy
Address:	11800 Weston Parkway Cary, NC 27513		1120 Stevenson Mill Rd., Suite 400 Coraopolis, PA 15108
NCPDP #:	3430369		6008002
Phone #:	1-833-TAVNEOS (1-833-828-6367)		

1 PRESCRIBER INFORMATION

Prescriber Name _____ NPI # _____ Specialty _____

Clinic/Facility _____ Contact Name _____ Contact Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

2 PATIENT INFORMATION

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 (for patient) _____ Phone _____ Relationship _____

3 CLINICAL INFORMATION

❑ I77.82	ANCA-associated vasculitis, ANCA positive vasculitis (GPA or MPA)			❑ I77.6	Unspecified Arteritis† †The diagnosis is related to antineutrophil cytoplasmic antibody (ANCA)-Associated Vasculitis or MPA/GPA, specifically; and confirmed or awaiting confirmation using one or more lab tests: ANCA serum/biopsy/urinalysis.
❑ M31.3	Granulomatosis with polyangiitis (GPA)*	❑ M31.30	Granulomatosis with polyangiitis (GPA)* without renal involvement		
❑ M31.31	Granulomatosis with polyangiitis (GPA)* with renal involvement	❑ M31.7	Microscopic polyangiitis (MPA)	❑ Other ICD-10 Code	_____
				Description (required)	_____

*GPA is formerly known as Wegener's granulomatosis.

Current Medication(s) _____

Known Drug Allergies _____

4 QUICK START PROGRAM REQUEST (only required if requesting Quick Start)

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.

❑ **Quick Start Request:** I authorize the dispensing pharmacy to dispense, using a copy of the Rx written on this form, attached, or provided electronically, per program business rules.

Only complete this section if your patient started TAVNEOS® in the hospital.

Contact Name _____ Contact Phone _____

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

Outpatient HCP _____ Phone _____ Fax _____

5 PRESCRIPTION (Rx)

If your state law requires it, or you prefer to submit a separate Rx, please submit via the appropriate method.‡

Specialty Pharmacy Prescription: TAVNEOS® (avacopan)	Quick Start Prescription: TAVNEOS® (avacopan)
Strength *10 mg* Quantity *180* ❑ **11 refills, or _____ refills**	Strength *10 mg* Quantity *90* **Refills** *1*
Directions for Use: *Take three (3) capsules by mouth twice daily with food*	Directions for Use: *Take three (3) capsules by mouth twice daily with food*

Prescriber Signature _____ **Date** _____

‡*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.

TAVNEOS®
(avacopan)

6 INSURANCE INFORMATION

Does the patient have insurance? ❑ Yes ❑ No

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

Is there an approved Prior Authorization (PA) on file? ❑ Yes ❑ No

7 HCP ATTESTATION & AUTHORIZATION

By completing and faxing this form, you represent that your patient has requested and authorized the disclosure of their personal health information to Amgen and its agents for Amgen to provide the patient support services described in this paragraph. You represent that you have explained to the patient, and the patient indicated they understand and have consented to, the following: 1) Amgen and its agents will use the patient's name, date of birth, contact information, prescriptions, and other necessary health information listed in this form for reimbursement services related to this prescription, including to verify their insurance benefits, to assess the patient's eligibility for the TAVNEOS® Quick Start and Copay programs, and, if eligible, to enroll the patient in the programs, and to contact the patient directly for the administration of these patient support services; 2) Amgen will then disclose the patient's personal information to the insurer(s) listed on this form for the same purposes; 3) the patient can withdraw their consent by contacting Amgen at 1-833-TAVNEOS (833-828-6367) or visiting www.amgen.com/DataSubjectRights, but if the patient does not agree to, or withdraws consent for, these uses and disclosures, the patient cannot receive these patient support services for this medication which necessarily requires Amgen to process the patient's personal information; and 4) the patient can view more details about Amgen's privacy practice at www.amgen.com/privacy.

Provide all information on this form unless it is not applicable.

For assistance, please call 1-833-TAVNEOS (1-833-828-6367).

Amgen Inc.
One Amgen Center Drive Thousand Oaks, CA 91320-1799
www.amgen.com

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