Health Partners
A part of Jefferson Health Plans

**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# Tavneos - Non PDL

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.**

| | | |
|---|---|---|
| Patient Name: | Prescriber Name: | |
| HPP HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Patient Primary Phone: | NPI: | *PA PROMISe ID:* |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Line of Business: ☐ Medicaid ☐ CHIP | *Specialty Pharmacy (if applicable):* | |
| **Drug Name:** | **Strength:** | |
| **Quantity:** | **Refills:** | |
| **Directions:** | | |
| **Diagnosis Code:** | **Diagnosis:** | |

*HPP's maximum approval time is 12 months but may be less depending on the drug.*

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
***Please answer the following questions and sign.***

Q1. Is the patient prescribed a dose and duration of therapy consistent with the FDA approved package labeling?

☐ Yes ☐ No

Q2. Is this a request for a renewal? If YES, go to question 3. If NO, go to question 4.

☐ Yes ☐ No

Q3. Is there documentation of positive clinical response and/or tolerance to the requested medication?

☐ Yes ☐ No

Q4. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q5. Is there documentation of an active diagnosis of severe active ANCA-associated vasculitis of one of the following types?

a. Granulomatosis with polyangiitis (GPA)
b. Microscopic polyangiitis (MPA)

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|---|---|

☐ Yes ☐ No

Q6. Is there documentation that this will be used as adjunctive OR in combination with standard therapy (e.g., prednisone, azathioprine, mycophenolate, methotrexate, rituximab, cyclophosphamide)?

☐ Yes ☐ No

Q7. Is the medication prescribed by or in consultation with rheumatologist, nephrologist, or immunologist?

☐ Yes ☐ No

Q8. Does the patient have Eosinophilic Granulomatosis with Polyangiitis (EGPA), also known as Churg-Strauss syndrome?

☐ Yes ☐ No

Q9. Additional Information:

Prescriber Signature

Date

*v2024*