



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Tavneos - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health 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.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**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 request for Tavneos for reauthorization?

Yes

No

Q2. Is there confirmation of disease stability or improvement?

Yes

No

Q3. Does the patient have a documented diagnosis of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA])?

Yes

No

Q4. Is Tavneos being prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.?

Yes

No

Q5. Is the patient 18 years of age or older?

Yes

No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Tavneos - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health 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.

Member Name:	Prescriber Name:
Q6. Will Tavneos be used as adjunct to standard therapy OR in combination with standard therapy (e.g., rituximab, cyclophosphamide, mycophenolate, azathioprine, and/or glucocorticoids)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other
Q8. Additional Information:	

Prescriber Signature

Date

v2025