maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Sohonos

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?
[] Fibrodysplasia ossificans progressiva (If checked, go to 2)

[] Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions)

[] Osteochondroma (If checked, no further questions)

[] Other (If checked, no further questions)

2 Is the requested medication being prescribed by or in consultation with an endocrinologist, orthopedic surgeon, or physician who specializes in metabolic disease? [If no, no further questions.] Yes No

If you have any questions, call: 1-888-258-8250

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3	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]		
5	Has the patient been established on the requested medication for at least 3 months? [Note: A patient who has received less than 3 months of therapy or who is restarting therapy with this medication is reviewed under Initial Authorization Criteria] [If no, skip to question 9.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
7	Has documentation been provided to confirm that according to the prescriber, the patient has a clinical benefit from the use of the requested medication in at least one of the following: (i) Positive change in baseline of physical function; (ii) Reduction in flare ups; (iii) Improvement in heterotopic ossification volume; (iv) Positive change in pain/swelling, angiogenesis, or inflammation biomarkers? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Has documentation been provided to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	What is the patient's gender? [Note: Males are defined as individuals with the biological traits of a male, regardless of the individual's gender identity or gender expression; females are defined as individuals with the biological traits of a female, regardless of the individual's gender identity or gender expression.] [] Male (if checked, go to 10) [] Female (if checked, go to 11)		
10	Is the patient greater than or equal to 10 year(s) of age? [If yes, skip to question 15.] [If no, no further questions.]	Yes	No
11	Is the patient greater than or equal to 8 year(s) of age? [If no, no further questions.]	Yes	No
12	Is the patient of childbearing potential? [If no, skip to question 15.]	Yes	No

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13	Does the provider attest that the female patient of childbearing potential have a negative pregnancy test within 30 days of requesting treatment? [If no, no further questions.]	Yes	No
14	Does the patient agree to use two effective methods of birth control during treatment and for at least one month after? [If no, no further questions.]	Yes	No
15	Has documentation been provided to confirm that the patient has had a genetic test confirming a mutation in Activin A Type 1 Receptor (ACVR1)R206H consistent with a diagnosis of fibrodysplasia ossificans progressiva? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the patient has baseline heterotopic ossification volume as confirmed by radiologic testing through whole body computed tomography (WBCT), excluding head? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Does the patient have a history of suicidal ideation within the past 30 days of requesting treatment? [If yes, no further questions.]	Yes	No
18	Does the patient have a history of allergy or hypersensitivity to retinoids, or to any component of Sohonos (palovarotene)? [If yes, no further questions.]	Yes	No
19	Will the patient be concurrently using vitamin A, beta carotene, or multivitamins/herbal products containing vitamin A, beta carotene, or fish oil with the requested medication? [If yes, no further questions.]	Yes	No
20	Does the provider attest that the patient has documented laboratory values within 30 days of requesting treatment that do NOT show amylase or lipase GREATER THAN 2x above the upper limit normal (ULN) or a history of pancreatitis? [If no, no further questions.]	Yes	No
21	Does the provider attest that the patient has documented laboratory values within 30 days of requesting treatment that do NOT show elevated aspartate aminotransferase or alanine aminotransferase GREATER THAN 2.5x the upper limit normal (ULN)? [If no, no further questions.]	Yes	No
22	Does the provider attest that the patient has documented laboratory values within 30 days of requesting treatment that do NOT show fasting triglycerides GREATER THAN 400 mg/dL?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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