



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**. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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|---|--|-------------|
| 1 | Is this request for initial therapy or for a continuation of therapy? | |
| | ☐ Initial (If checked, go to 7) | |
| | ☐ Continuation (If checked, go to 2) | |
| 2 | Is the patient currently receiving the requested medication?
[If no, skip to question 7.] | Yes No |

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questions, call:
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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	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 7.]	Yes	No
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 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as evidenced by at least one of the following: A) Positive change in baseline of physical function, B) Reduction in flare ups, C) Improvement in heterotopic ossification volume, D) Positive change in pain/swelling, angiogenesis, or inflammation biomarkers? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the diagnosis or indication? ☐ Fibrodysplasia ossificans progressiva (If checked, go to 8) ☐ Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions) ☐ Osteochondroma (If checked, no further questions) ☐ Other (If checked, no further questions)		
8	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 9) ☐ Female (If checked, go to 10)		
9	Is the patient greater than or equal to 10 years of age? [If yes, skip to question 14.] [If no, no further questions.]	Yes	No

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10	Is the patient greater than or equal to 8 years of age? [If no, no further questions.]	Yes	No
11	Is the patient of childbearing potential? [If no, skip to question 14.]	Yes	No
12	Does the provider attest that the female patient of childbearing potential has had a negative pregnancy test within 30 days of requesting treatment? [If no, no further questions.]	Yes	No
13	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
14	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
15	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
16	Does the patient have a history of suicidal ideation within the past 30 days of requesting treatment? [If yes, no further questions.]	Yes	No
17	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
18	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
19	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
20	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)?	Yes	No

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[If no, no further questions.]

- | | | | |
|----|--|-----|----|
| 21 | 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?
[If no, no further questions.] | Yes | No |
| 22 | Is the requested medication being prescribed by or in consultation with an endocrinologist, orthopedic surgeon, or physician who specializes in fibrodysplasia ossificans progressiva?
[If no, no further questions.] | Yes | No |
| 23 | Does the requested dose exceed the FDA approved label dosing for the indication? | Yes | No |

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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