PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Sohonos - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Sohonos - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Sohonos (palovarotene)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Will the requested medication be used for any indications or uses that are NOT Food and Drug Administration (FDA)-approved, or guideline-supported?	Y N
[If yes, no further questions.]	
2. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this	Y N

	plan)?		
	NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.		
	[If no, skip to question 4.]		
3.	Has the patient had a beneficial response to treatment with the requested medication, evidenced by a reduction in annualized HO volume?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 10.]		
	[If no, no further questions.]		
4.	Does the patient have a diagnosis of fibrodysplasia ossificans progressiva (FOP)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
5.	Does the patient have Activin A Type 1 Receptor (ACVR1) R206H variant mutation as confirmed by genetic testing?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Does the patient have radiographic evidence of heterotopic ossification (HO) (computed tomography (CT) scan, magnetic resonance imaging (MRI), x-ray, positron emission tomography (PET) scan, etc.)?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Is the requested medication being used in a female with reproductive potential?	Y N	
	[If no, skip to question 9.]		
8.	Has the patient had a negative pregnancy test prior to initiation of therapy, and will use an effective method of contraception during treatment?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
9.	Is the requested medication being prescribed by, or in consultation with, an endocrinologist, geneticist, or a provider specializing in FOP management?	Y N	
	[If no, no further questions.]		
10.	Is the requested medication being used in a patient designated as female at birth?	Y N	
	[If no, skip to question 12.]		
11.	Is the patient 8 years of age or older?	Y N	
	[If yes, skip to question 14.]		
	[If no, no further questions.]		

12. Is the requested medication being used in a patient designated as male at birth?	Y N
[If no, no further questions.]	
13. Is the patient 10 years of age or older?	Y N
[If no, no further questions.]	
14. Does the patient meet ANY of the following: A) pregnant or breastfeeding, B) moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment C) severe renal impairment, or D) history of allergy or hypersensitivity to retinoids, or to any component of the requested medication?	Y N
[If yes, no further questions.]	
15. Will the requested medication be used concurrently with ANY of the following: A) strong cytochrome P450 3A4 (CYP3A4) inhibitors, moderate or strong CYP3A4 inducers or B) tetracyclines?	Y N
[If yes, no further questions.]	
16. Is the requested drug being prescribed for FDA-approved dosages and dosing intervals?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date