TRICARE Prior Authorization Request Form for
palovarotene (Sohonos)

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial prior authorization expires after 1 year. After 1 year, a new PA must be resubmitted. For renewal of therapy, an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Sohonos.*	☐ Yes Proceed to question **2**	☐ No Skip to question **4**
2. Has the patient had a positive response to therapy?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Do the benefits outweigh the risks of continued use of therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a diagnosis of Fibrodysplasia Ossificans Progressiva confirmed with a genetic test?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the requested medication prescribed by a provider who specializes in the treatment of Fibrodysplasia Ossificans Progressiva?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the provider aware of the warnings, screening and monitoring precautions for Sohonos?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the patient a pediatric patient?	☐ Yes Proceed to question **8**	☐ No Proceed to question **9**

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8. Will the pediatric patient with open epiphyseal plates undergo assessments of skeletal maturity and linear growth prior to the first dose and every 6 to 12 months thereafter until reaching skeletal maturity or final adult height?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the patient's gender?	☐ Female Proceed to question **10**	☐ Male Proceed to question **15**
10. Is the patient greater than or equal to 8 years of age?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient of childbearing potential?	☐ Yes Proceed to question **12**	☐ No **Sign and date below**
12. Has the patient been counseled to use effective contraception 1 month prior to treatment, during treatment and for 1 month after the cessation of therapy?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Has it been confirmed that the patient is not pregnant by negative hCG (human chorionic gonadotropin) prior to the first dose and then periodically during treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
15. Is the patient greater than or equal to 10 years of age?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[14 Feb 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: