



Updated: 09/2025

DMMA Approved: 09/2025

**Request for Prior Authorization for Sohonos (palovarotene)**

**Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)**

**Submit request via: Fax - 1-855-476-4158**

All requests for Sohonos (palovarotene) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Sohonos (palovarotene) Prior Authorization Criteria:**

Coverage may be provided with a diagnosis of fibrodysplasia ossificans progressiva (FOP) and the following criteria is met:

- Prescribed by or in consultation with an orthopedist or rheumatologist
- Documented ACVR1 mutation
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Documentation of improvement or stabilization in disease.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.



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**SOHONOS (PALOVAROTENE)  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251** Mon – Fri 8:00 am to 7:00 pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:	
Member ID:	Member weight:	Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:	
Directions:	Quantity:	Refills:

Is the member currently receiving requested medication?  Yes  No Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient?  Yes  No

**Billing Information**

This medication will be billed: <input type="checkbox"/> at a pharmacy <b>OR</b> <input type="checkbox"/> medically, JCODE:
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

Diagnosis:	ICD Code:
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Does the member have a ACVR1 mutation?  Yes  No

**CURRENT or PREVIOUS THERAPY**

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**REAUTHORIZATION**

Has the member experienced stabilization or improvement with treatment?  Yes  No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

Prescribing Provider Signature	Date