Sohonos Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 6020 Ave Roberto Sanchez Vilella Carolina, PR 00982 **NCPDP:** 4026325

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ DOB: _____ Gender: ☐ Male ☐ Female
Address: _____City, State, ZIP Code: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: _____ Alternate Phone: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____
Parent/Caregiver/Legal Guardian Name (Last, First): _____**Relationship to patient**: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP Code: _____
Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

Is the Patient Insured? Yes☐ No☐ Is the Patient enrolled or eligible for Medicare/Medicaid? Yes☐ No☐
Policy Holder's Name:_____ Policy Holder's DOB:_____ Relationship to Patient:_____
Medical Insurance: _____ Telephone: _____ Policy ID: _____ Group #: __ _____
Prescription Insurance: _____ Prescription Plan Telephone: _____
Policy ID: _____ Group #: _____ RX BIN #: _____ RX PCN #:_____ _____
Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# _____

4 DIAGNOSIS (ICD-10) AND CLINICAL INFORMATION

Needs by date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

Diagnosis (ICD-10):

☐ M61.1 Myositis ossificans progressiva ☐ Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

Height: ____in/cm:

Weight: _____lb or _____kg

Date Weight Recorded: _____

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Please Complete Patient and Prescriber Information

Patient Name: _____ Patient Address: _____Patient DOB: _____

Patient Phone: _____Prescriber Name: _____Prescriber Phone: _____

Patient Clinical Information:

Allergies: _____ Weight: _____lb/kg Height: _____in/cm

5 PRESCRIPTION INFORMATION

Chronic or Alternate Dosing

MEDICATION	STRENGTH (Multiple if applicable)	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Sohonos Capsules	☐ 1 mg capsule ☐ 1.5 mg capsule ☐ 2.5 mg capsule ☐ 5 mg capsule ☐ 10 mg capsule	Take _____ mg (total daily dose) by mouth daily	Quantity: 28-day supply Refills: 13 or ____

Flare Up Dosing (Weeks 1-4)

MEDICATION	STRENGTH (Multiple if applicable)	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Sohonos Capsules	☐ 1 mg capsule ☐ 1.5 mg capsule ☐ 2.5 mg capsule ☐ 5 mg capsule ☐ 10 mg capsule	FOR FLARE UPS: Take _____ mg (total daily dose) by mouth daily for weeks 1-4	Quantity: 28-day supply Refills: NONE

Flare Up Dosing (Weeks 5-12)

MEDICATION	STRENGTH (Multiple if applicable)	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Sohonos Capsules	☐ 1 mg capsule ☐ 1.5 mg capsule ☐ 2.5 mg capsule ☐ 5 mg capsule ☐ 10 mg capsule	FOR FLARE UPS: Take _____ mg (total daily dose) by mouth daily for weeks 5-12	Quantity: 28-day supply Refills: 1

Prescriber Dosing Reference Section

Table 1: Sohonos Dosage Guidance

Patient Weight	Chronic Dosing	Flare up (Weeks 1-4)	Flare up (Weeks 5-12)
≥ 60 kg or ≥ 14 years of age	5 mg	20 mg	10 mg
Weight Based only for Children < 14 Years of Age			
40 - < 60 kg	4 mg	15 mg	7.5 mg
20 - < 40 kg	3 mg	12.5 mg	6 mg
10 - < 20 kg	2.5 mg	10 mg	5 mg

Table 2: Dose Reduction Guidance for intolerable side effects - (during chronic or flare ups)

Prescribed Dose	Reduced Dose	Prescribed Dose	Reduced Dose
20 mg	15 mg	**6 mg**	4 mg
15 mg	12.5 mg	**5 mg**	2.5 mg
12.5 mg	10 mg	**4 mg**	2 mg
10 mg	7.5 mg	**3 mg**	1.5 mg
7.5 mg	5 mg	**2.5 mg**	1 mg

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature: _____Date: _____**	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature: _____Date: _____**

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" _____**ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty® Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature. CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.
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