Sohonos Enrollment Form

CVS specialty®

Fax Referral To: 1-855-330-1718 **Phone:** 1-866-247-7514

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. 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: _____

If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____

Relationship to minor: _____

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)

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: _____

Sohonos Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: _____ Patient DOB: _____

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) *only if necessary for patient

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: NONE

Flare Up Dosing (Weeks 5-12) *only if necessary for patient

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: 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.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Specialty® and/or one of its affiliates.