AETNA BETTER HEALTH® Coverage Policy/Guideline					
Name:	me: Sohonos (palovarotene)		Page:	1 of 3	
Effective Date: 12/26/2023			Last Review Date:	10/5/2023	
Applies	⊠Illinois	□Florida	⊠New Je	ersey	
to:	□Maryland	⊠Florida Kids	⊠Pennsylvania Kids		
ιο.	□Michigan	⊠Virginia			

#### Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Sohonos under the patient's prescription drug benefit.

### **Description:**

#### **FDA-Approved Indication**

Sohonos is indicated for the reduction in volume of new heterotopic ossification in adults and pediatric patients aged 8 years and older for females and 10 years and older for males with fibrodysplasia ossificans progressiva (FOP).

All other indications are considered experimental/investigational and not medically necessary.

## **Applicable Drug List:**

**Sohonos** 

#### **Policy/Guideline:**

#### **Criteria for Initial Approval:**

- I. Submission of the following information is necessary to initiate the prior authorization review:
  - A. Initial requests:
    - 1. Genetic testing results confirming diagnosis of fibrodysplasia ossificans progressiva (FOP) with documented *activin receptor type 1 (ACVR1)* mutation (e.g., R206H).
    - 2. Chart notes or medical record documentation supporting signs and symptoms of FOP.
- II. Fibrodysplasia ossificans progressiva (FOP)

Authorization may be granted for reduction in the volume of new heterotopic ossification in fibrodysplasia ossificans progressiva (FOP) when ALL the following criteria are met::

- A. Sohonos is prescribed by or in consultation with a physician who is experienced in the treatment of fibrodysplasia ossificans progressiva (FOP) (e.g., orthopedist, rheumatologist).
- B. Member has a genetically confirmed diagnosis of FOP with genetic testing indicating the patient has an *activin receptor type 1 (ACVR1)* mutation (e.g., R206H).

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- C. Member has signs and symptoms of FOP (e.g., malformation of the great toe, abnormal vertebral morphology, ectopic ossification in ligament or muscle tissue).
- D. Member meets EITHER of the following age criteria:
  - 1. Member is a male 10 years of age or older.
  - 2. Member is a female 8 years of age or older

### **Criteria for Continuation of Therapy**

# III. Submission of the following information is necessary for continuation of therapy:

A. Chart notes or medical record documentation supporting benefit from therapy.

# IV. Authorization may be granted for continuation of therapy when ALL the following criteria are met:

- A. Member meets EITHER of the following age criteria:
  - 1. Member is a male 10 years of age or older.
  - 2. Member is a female 8 years of age or older
- B. Member is experiencing benefit from therapy as evidenced by disease stability or disease improvement (e.g., reduction in the volume of new heterotopic ossification).
- C. Sohonos is prescribed by or in consultation with a physician who is experienced in the treatment of fibrodysplasia ossificans progressiva (FOP) (e.g., orthopedist, rheumatologist).

### **Approval Duration and Quantity Restrictions:**

Initial Approval: 12 months

## **Quantity Level Limit:**

Medication	Quantity Level Limit	FDA-recommended dosing
Sohonos 1mg	28 capsules per 28 days	Patients ≥14 years: 5mg QD
Sohonos 1.5mg	56 capsules for 28 days	Flare-up dose: 20mg QD for 4 weeks, followed by 10mg QD x 8 wks
Sohonos 2.5mg	28 capsules per 28 days	
Sohonos 5mg	28 capsules per 28 days	Patients ≤13 years: 2.5mg to 5mg QD based on weight
Sohonos 10mg	56 capsules per 28 days	Flare-up dose: 10mg to 20mg QD x 4 wks, followed by 5mg to 10mg QD x 8 wks based on weight

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### **References:**

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