Fintepla

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____**Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis?
   - ❑ Seizures associated with Dravet syndrome
   - ❑ Seizures associated with Lennox-Gastaut syndrome
   - ❑ Other _____
2. What is the ICD-10 code? _____

Section A: Preferred Product

3. Is the product being requested for the treatment of seizure disorders?
4. The preferred products for your patient's health plan are clobazam, lamotrigine, rufinamide, topiramate, and Trokendi XR. Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - **Please specify: _____** ❑ No - continue request for non-preferred product
5. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #7*
6. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No *If No, skip to next section.*
7. Does the patient have a diagnosis of seizures associated with Dravet syndrome?
   If Yes, skip to next section. ❑ Yes ❑ No
8. Does the patient have a documented inadequate response to treatment with at least 3 of the preferred product(s) (clobazam, lamotrigine, rufinamide, topiramate, Trokendi XR)? ***ACTION REQUIRED: Submit supporting documentation.*** *If Yes, skip to next section.* ❑ Yes ❑ No
9. Does the patient have a documented intolerable adverse event to at least 3 of the preferred product(s) (clobazam, lamotrigine, rufinamide, topiramate, Trokendi XR)? ***ACTION REQUIRED: Submit supporting documentation.***
   ❑ Yes ❑ No

Section B: All Requests

10. Will Fintepla be taken in combination with phentermine? ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

11. Is the request for continuation of therapy with the requested medication?
    ❑ Yes ❑ No *If No, no further questions*

12. Has the member achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of seizures compared with seizure activity prior to starting Fintepla? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature Date (mm/dd/yy)

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155