BlueCross BlueShield Federal Employee Program

FINTEPLA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Fintepla (fenfluramine)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many milliliters (mL) will the patient need for a 90 day supply? _____ mL per 90 days

1. What is the patient's diagnosis?
   - ❑ Seizures associated with Dravet Syndrome (DS)
   - ❑ Seizures associated with Lennox-Gastaut Syndrome (LGS)
   - ❑ Other diagnosis ***(please specify)***:_____

2. Is Fintepla being used for weight loss? ❑Yes ❑No

3. Is the patient using Fintepla in combination with Diacomit (stiripentol)? ***Please select answer below:***
   - ❑ **Yes**: Does the prescriber agree to administer Fintepla within the FDA labeled maintenance dose of 17mg per day? ❑Yes ❑No
   - ❑ **No**: Does the prescriber agree to administer Fintepla within the FDA labeled maintenance dose of 26mg per day? ❑Yes ❑No

4. Has the patient been on Fintepla continuously for the last **6 months**, excluding samples? ***Please select answer below:***

   ❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

   a. Is the patient currently taking **TWO** concomitant anti-seizure medications: clobazam, valproate/valproic acid (i.e., Depakote, Depacon), lamotrigine, levetiracetam, Banzal (rufinamide), topiramate, felbamate, or stiripentol (Dravet syndrome **only**)? ❑Yes ❑No*

   ***If NO**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** concomitant anti-seizure medications? ❑Yes ❑No

   b. Is the patient currently taking any monoamine oxidative inhibitors? ❑Yes* ❑No

   ***If YES**, will the patient be tapered off the monoamine oxidative inhibitor at least 14 days prior to starting Fintepla? ❑Yes ❑No

   c. Are the patient and the prescriber both enrolled in the Fintepla REMS program? ❑Yes ❑No

   d. Does the prescriber agree to monitor echocardiogram before initiating therapy, every six months while on therapy, and three to six months after the final dose? ❑Yes ❑No

   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

   a. Has the patient experienced a reduction in the frequency of seizures while on Fintepla therapy? ❑Yes ❑No

   b. Will the patient be taking monoamine oxidative inhibitors while on Fintepla therapy? ❑Yes ❑No

   c. Does the prescriber agree to monitor echocardiogram every six months while on therapy, and three to six months after the final dose? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Fintepla – FEP MD Fax Form Revised 5/27/2022

BlueCross BlueShield
Federal Employee Program

FINTEPLA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***