SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Fintepla® (fenfluramine)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage:

	Without concomitant stiripentol		**Without concomitant stiripentol**	
	Weight-based Dosage	**Maximum Total Daily Dosage**	**Weight-based Dosage**	**Maximum Total Daily Dosage**
Initial Dosage:	0.1 mg/kg twice daily	26 mg	0.1 mg/kg twice daily	17 mg
Day 7	0.2 mg/kg twice daily	26 mg	0.15 mg/kg twice daily	17 mg
Day 7	0.35 mg/kg twice daily	26 mg	0.2 mg/kg twice daily	17 mg

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

- ❑ Medication must be prescribed by or in consultation with a neurologist
- ❑ Member must be 2 years of age or older
- ❑ Member must have **ONE** of the following diagnoses **(must submit chart notes to confirm diagnosis)**:
  - ❑ Seizures associated with Dravet syndrome (DS)
  - ❑ Seizures associated with Lennox-Gastaut syndrome (LGS)
- ❑ Member has trial and failure to at least 2 preferred formulary anticonvulsant drugs

Medication being provided by Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 9/17/2020
REVISED/UPDATED/REFORMATTED: ~~12/7/2020; 5/13/2022; 6/3/2022; 6/17/2022; 11/7/2023;~~ **9/30/2024**