Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Fintepla - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have hypersensitivity to Fintepla or any of the components of Fintepla?

☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of Dravet syndrome (DS)?

☐ Yes ☐ No

Q3. Is there documentation of an inadequate response or intolerance to at least two of agents to treat Dravet syndrome: such as clobazam, valproic acid derivatives, topiramate, levetiracetam, cannabidiol (pharmaceutical), or stiripentol. (Include dates, duration, and outcome of agent tried)?

☐ Yes ☐ No

Q4. Does the patient have a documented diagnosis of Lennox-Gastaut syndrome (LGS)?

☐ Yes ☐ No

Q5. Is there documentation showing an inadequate response or intolerance to at least two agents to treat Lennox-Gastaut syndrome (LGS): such as lamotrigine, rufinamide, topiramate, cannabidiol (pharmaceutical), clobazam, felbamate. (Include dates, duration, and outcome of tried drugs)?

☐ Yes ☐ No

Q6. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q7. Is Fintepla being prescribed by a neurologist or epileptologist?

Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Fintepla - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Will Fintepla will be used with or within 14 days of administration of monoamine oxidase inhibitors?

☐ Yes ☐ No

Q9. Will patient have required echocardiogram monitoring?

☐ Yes ☐ No

Q10. Requested Duration:

☐ 12 months

Q11. Additional Information:

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request