



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Fintepla - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health 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.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	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,



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Fintepla - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health 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.

Member Name:	Prescriber Name:
cannabidiol (pharmaceutical), clobazam, felbamate. (Include dates, duration, and outcome of tried drugs)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the patient 2 years of age or older?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Is Fintepla being prescribed by or in consultation with a neurologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Will Fintepla will be used with or within 14 days of administration of monoamine oxidase inhibitors?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Will patient have required echocardiogram monitoring?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other:
Q11. Additional Information:	

Prescriber Signature

Date

v2025