US Family Health Plan
Prior Authorization Request Form for
fenfluramine oral solution (Fintepla)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial. Initial therapy approves for 6 months, renewal approves for 12 months. For renewal of therapy an initial USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. What is the indication or diagnosis? **Note: Non-FDA-approved uses are not approved including for weight loss.**	☐ Dravet Syndrome – Proceed to question **3** ☐ Lennox- Gastaut Syndrome– Proceed to question **3** ☐ Other – **STOP** Coverage not approved	
3. Will the requested medication be used as adjunct therapy with other anticonvulsant medications?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Does the prescriber abide by the REMS program including safety risks and requirements of regular echocardiogram (ECHO) monitoring for valvular heart disease and pulmonary hypertension?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Has the patient been informed of the REMS program including safety risks and requirements of regular echocardiogram (ECHO) monitoring for valvular heart disease and pulmonary hypertension?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature	Date

[28 September 2022]