Prior Authorization Request Form for
fenfluramine oral solution **(Fintepla)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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** ☐ 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

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

_____ _____
Prescriber Signature Date

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: