

# FINTEPLA

## PRIOR AUTHORIZATION REQUEST

### PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://covermymeds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:** \_\_\_\_\_

#### PATIENT AND INSURANCE INFORMATION

**Date of Service (if differs from Today's Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

#### PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

#### PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient diagnosis: <input type="checkbox"/> Dravet syndrome (DS) <input type="checkbox"/> Lennox-Gastaut syndrome (LGS) <input type="checkbox"/> Other (ICD code and description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b> 1. Is the patient currently treated with the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? <b>Please note, chart notes are required.</b> ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Does the patient have any FDA labeled contraindications to the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ 3. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., neurologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Will an echocardiogram assessment be obtained before and during treatment with the requested agent, to evaluate for valvular heart disease and pulmonary arterial hypertension? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Will the requested agent be used as monotherapy for seizure management? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Is the patient's age within FDA labeling for the requested indication for the requested agent? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ 8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____ _____ _____	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For Dravet syndrome (DS) requests, please submit chart notes to support the answers to the following questions:**

9. Has the patient tried and had an inadequate response to TWO generic antiseizure agents used in the treatment of DS (e.g., valproate, clobazam, stiripentol, topiramate)? .....  Yes  No
10. Has the patient tried and had an inadequate response to ONE generic antiseizure agent used in the treatment of DS, AND does the patient an intolerance or hypersensitivity to ONE OTHER generic antiseizure agent used in the treatment of DS (e.g., valproate, clobazam, topiramate)? .....  Yes  No
11. Does the patient have an intolerance or hypersensitivity to TWO generic antiseizure agents used in the treatment of DS (e.g., valproate, clobazam, topiramate)? .....  Yes  No
12. Does the patient have an FDA labeled contraindication to ALL generic antiseizure agents used in the treatment of DS? .....  Yes  No
13. Were TWO generic antiseizure agents used in the treatment of DS discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
14. Are TWO generic antiseizure agents used in the treatment of DS expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
15. Are TWO generic antiseizure agents used in the treatment of DS not in the best interest of the patient based on medical necessity? .....  Yes  No
16. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO generic antiseizure agents used in the treatment of DS and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For Lennox-Gastaut syndrome (LGS) requests, please submit chart notes to support the answers to the following questions:**

17. Has the patient tried and had an inadequate response to TWO generic antiseizure agents used in the treatment of LGS (e.g., valproate, lamotrigine, rufinamide, topiramate, clobazam, felbamate)? .....  Yes  No
18. Has the patient tried and had an inadequate response to ONE generic antiseizure agent used in the treatment of LGS, AND does the patient have an intolerance or hypersensitivity to ONE OTHER generic antiseizure agent used in the treatment of LGS (e.g., valproate, lamotrigine, rufinamide, topiramate, clobazam, felbamate)? .....  Yes  No
19. Does the patient have an intolerance or hypersensitivity to TWO generic antiseizure agents used in the treatment of LGS (e.g., valproate, lamotrigine, rufinamide, topiramate, clobazam, felbamate)? .....  Yes  No
20. Does the patient have an FDA labeled contraindication to ALL generic antiseizure agents used in the treatment of LGS? .....  Yes  No
21. Were TWO generic antiseizure agents used in the treatment of LGS were discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
22. Are TWO generic antiseizure agents used in the treatment of LGS are expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? .....  Yes  No
23. Are TWO generic antiseizure agents used in the treatment of LGS are not in the best interest of the patient based on medical necessity? .....  Yes  No
24. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO generic antiseizure agents used in the treatment of LGS and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For all renewal requests:**

25. Has the patient had clinical benefit with the requested agent? .....  Yes  No
26. Will an echocardiogram assessment be obtained during treatment with the requested agent to evaluate for valvular heart disease and pulmonary arterial hypertension? .....  Yes  No
27. Will the patient be using the requested agent for seizure management associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS)? .....  Yes  No  
If yes, will the requested agent be used as monotherapy? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:**

**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

**Fax: 877.243.6930**

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