Prescriber Criteria Form

Fintepla 2025 PA Fax 3983-A v1 010125.docx
Fintepla (fenfluramine)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fintepla (fenfluramine).

Drug Name:
Fintepla (fenfluramine)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of Dravet syndrome? [If yes, then skip to question 3.]	Yes	No
2	Does the patient have a diagnosis of Lennox-Gastaut syndrome? [If no, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of seizures associated with the patient's condition? [If no, then no further questions.]	Yes	No
4	Is the patient 2 years of age or older?	Yes	No

Comments: ____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _________________________________ **Date:**____________________