# FINTEPLA Prescription Authorization and Patient Referral Form

Fintepla® (fenfluramine) 2.2 mg/mL oral solution

Please complete all fields and fax the form and attachments to **1-888-250-6103** or submit the form and attachments on the Provider Portal (**ONWARDProviderPortal.com**).

## SECTION 1: PATIENT/INSURANCE INFORMATION **Attach a copy (front and back of insurance card[s])**

| | | | |
|---|---|---|---|
| First Name: | Last Name: | Date of Birth (MM/DD/YYYY): / / | Gender: |
| Address Line 1: | | Address Line 2 (optional): | |
| City: | | State: | ZIP Code: |
| Preferred Phone #: - - | | Other Phone #: - - | |
| Caregiver Name: | Relationship to Patient: | Caregiver Phone # (if different from above): - - | |

| | |
|---|---|
| Primary Insurance Name: | Secondary Insurance Name (if available): |
| Phone #: - - | Phone #: - - |
| Policy Holder's Name: | Policy Holder's Name: |
| Policy #: Group #: | Policy #: Group #: |

## SECTION 2: PRESCRIBER INFORMATION & PRESCRIPTION **Completed by the doctor**

| | | | | |
|---|---|---|---|---|
| Prescriber Name: | | | Tax ID #: | |
| Address: | | | Name of Contact Person: | |
| City: | State: | ZIP Code: | Phone #: - - | Fax #: - - |
| NPI: | | | | |

**Prescription (to be completed for all patients)**

Drug: FINTEPLA (fenfluramine) 2.2 mg/mL oral solution

Patient's Weight: _____ kg  Gastric Feeding Tube ☐ Yes ☐ No

Sig. Take _____ mL **(round to the nearest tenth)** PO BID for _____ days,
Take _____ mL **(round to the nearest tenth)** PO BID for _____ days,
Take _____ mL **(round to the nearest tenth)** PO BID thereafter

Special Instructions:

Quantity (based on maintenance dose): _____ mL  Days' Supply: _____  Refills: _____

**Suggested Titration Schedule***

| | Weight-based dosing† | Calculated Dose Examples for Patients Weighing: | | |
|---|---|---|---|---|
| | | 22 kg | 44 kg | 66 kg |
| **Initial Dose** | 0.1 mg/kg BID | 1 mL BID | 2 mL BID | 3 mL BID |
| **Titration Dose (Day 7)** | 0.2 mg/kg BID | 2 mL BID | 4 mL BID | 5.9 mL BID |
| **Maintenance Dose (Day 14)** | 0.35 mg/kg BID | 3.5 mL BID | 5.9 mL BID | 5.9 mL BID |
| **Maximum total daily dose mg: 26 mg* (13 mg BID)** | | **Maximum total daily dose mL: 11.8 mL* (5.9 mL BID)** | | |

*If patient is taking stiripentol or a strong CYP1A2 or CYP2D6 inhibitor; has severe renal impairment; or has mild, moderate, or severe hepatic impairment, see full Prescribing Information for dose adjustments and maximum dosage.

†To calculate: Weight (kg) x dosage (mg/kg) ÷ 2.2 mg/mL = mL dose BID.

**Diagnosis** (Describe how diagnosis was made and attach supporting documentation/test results)

Seizures are associated with: ☐ Dravet syndrome (DS) ☐ Lennox-Gastaut syndrome (LGS)

ICD-10 Code:
- ☐ G40.83 (DS); Polymorphic epilepsy in infancy (PMEI); Severe myoclonic epilepsy in infancy (SMEI)
- ☐ G40.833 (DS) intractable, with status epilepticus
- ☐ G40.834 (DS) intractable, without status epilepticus
- ☐ G40.81 (LGS)
- ☐ G40.811 (LGS) not intractable, with status epilepticus
- ☐ G40.812 (LGS) not intractable, without status epilepticus
- ☐ G40.813 (LGS) intractable, with status epilepticus
- ☐ G40.814 (LGS) intractable, without status epilepticus
- ☐ Other ICD-10 _____

**Select if the patient has had trial and failure of, contraindication to, or intolerance to any of the following medications:**

- ☐ Banzel (rufinamide)
- ☐ Depakote, Depakene (divalproex sodium, valproic acid)
- ☐ Diacomit (stiripentol)
- ☐ Epidiolex (cannabidiol)
- ☐ Felbatol (felbamate)
- ☐ Keppra, Elepsia, Spritam (levetiracetam)
- ☐ Lamictal (lamotrigine)
- ☐ Luminal, Solfoton (phenobarbital)
- ☐ Onfi, Sympazan (clobazam)
- ☐ Topamax, Qudexy (topiramate)
- ☐ Zarontin (ethosuximide)
- ☐ Zonegran (zonisamide)
- ☐ Other anticonvulsant(s)

**Does patient have any allergies?** ☐ Yes ☐ No  List the allergies: _____

**Prescriber Agreement**

By signing below, I certify the following:

The above therapy is medically necessary and in the best interest of the named patient. I have received the appropriate permission from the patient (or the patient's legal representative). I have met any other applicable legal or regulatory requirements, such as those required by the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to give the above information to UCB, Inc. and its agents. I have received the patient's authorization to share the above information and other information as may be required by AnovoRx Manufacturer Services, LLC as UCB, Inc.'s agent and its employees to assist in getting coverage for this drug. I appoint AnovoRx Manufacturer Services, LLC as my agent for the purposes of conveying this prescription to the appropriate dispensing pharmacy; verifying the patient's insurance coverage for FINTEPLA; providing information regarding payer coverage and benefits and how to prepare prior authorization requests, coverage determination appeals, or other coverage issues; and providing my patient and me with educational and support services associated with FINTEPLA.

**Dispense as Written:** _____  **Substitution Allowed:** _____

Print Name: _____  Date: / /

## SECTION 3: PATIENT AUTHORIZATION FOR ONWARD™ SUPPORT SERVICES

**This section to be completed and signed by new patient or caregiver.**

**Required to enroll in ONWARD Support Program. This form needs to be completed only once to enroll.**
**By signing this Authorization, I agree to the following:**

I authorize my healthcare providers, health plans, and pharmacy providers to disclose my personal health information, including information relating to my medical condition, treatment, care management, and health insurance, as well as all information provided on this form and any information about my prescriptions ("Personal Health Information"), to ONWARD and its representatives, agents, contractors, and affiliates (collectively, "UCB, Inc.") in order for UCB, Inc. to provide product support services.

I further authorize UCB, Inc. to use and disclose my Personal Health Information to third parties, including, but not limited to, specialty pharmacies, health plans, insurance companies, and patient assistance programs solely for such ONWARD product support services, including investigating insurance benefits, eligibility, and coverage; providing financial assistance for copay or out-of-pocket payments; eligibility for free medication supply; coordinating care; coordinating delivery of medication; and communicating with me by mail, email, text, or telephone. I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify ONWARD promptly if any of my numbers change in the future. I understand that my wireless service provider's message and data rates may apply. I understand that I can opt out from future text messages by responding STOP to any text. I also understand that additional text messaging terms and conditions may be provided to me in the future as part of an opt-in confirmation text message. I additionally consent to receive commercial email messages, letters, and/or educational resources from UCB, Inc.

I understand that my Personal Health Information, once disclosed to third parties under this Authorization, may no longer be protected by state and federal privacy laws and could be disclosed by UCB, Inc. as well as other recipients of the information. I understand that signing this Authorization is voluntary but that if I decide not to sign this Authorization, I will not be eligible to join ONWARD and receive its services and benefits for which I may qualify. I also understand that my treatment, payment, enrollment in a health plan, or eligibility for insurance benefits, including my access to therapy, is not conditioned on my signing this Authorization—only my eligibility for ONWARD. I understand that I am entitled to a signed copy of this Authorization.

I may choose to cancel this Authorization at any time and stop receiving ONWARD services, and, if I choose to cancel, I must do so in writing by sending notice of my cancellation to the following address: ONWARD, 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134. ONWARD personnel will convey the cancellation to all of my healthcare providers, health plans, and pharmacy providers that have received the Authorization. I also understand, however, that any such cancellation will not apply to any information already used or disclosed based on this Authorization prior to receipt of the cancellation by UCB, Inc. This Authorization expires ten (10) years from the date signed below.

Patient Name: _____ Patient Date of Birth: ___/___/___

**I, the patient or legal guardian, authorize the following individual to act as my representative. This individual has my full permission to obtain and disclose personal health information to UCB, Inc.**

Patient or Legal Guardian Signature: _____ Date: ___/___/___

Name of Patient Representative: _____ Relationship to Patient: _____

Home Phone #: ___-___-___ Mobile #: ___-___-___

Best Time to Call (optional): ☐ Morning ☐ Midday ☐ Evening Can We Leave a Message? ☐ Yes ☐ No

Email (optional): _____ Preferred Language: ☐ English ☐ Spanish ☐ Other

Patient's echocardiogram (echo) has been scheduled and/or completed: ☐ Yes ☐ No

**If yes:** Patient's echo appointment date: ___/___/___

Echo location: _____ Phone number of echo location: _____

**If you need help scheduling an echo, contact an ONWARD Care Coordinator for guidance at 1-888-964-3649.**

Inspired by patients. Driven by science.

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