



# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Fintepla® (fenfluramine) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand <input type="checkbox"/> Check if request is for initial trial <input type="checkbox"/> Check if request is for recertification of therapy			Directions for Use:		
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Recipient has a documented diagnosis of seizures associated with Dravet Syndrome.					
Drug-Specific Information (required)					
<b>All the following must be met:</b>					
<input type="checkbox"/> The medication is being prescribed by or in consultation with a neurologist.					
<input type="checkbox"/> For recertification, the recipient has documentation of positive clinical response to Fintepla® therapy.					

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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