FINTEPLA REMS Patient Status Form

FOR PRESCRIBERS

Prior to starting and during treatment, patients must undergo an echocardiogram to evaluate for cardiac abnormalities. The prescriber must consider the benefits versus the risks of initiating or continuing treatment with FINTEPLA if ANY of the following signs are observed on an echocardiogram:

- Valvular abnormality or new abnormality via echocardiogram
- Valvular heart disease (VHD) as indicated by mild or greater aortic regurgitation or moderate or greater mitral regurgitation, with additional characteristics of VHD (eg, valve thickening or restrictive valve motion)
- Pulmonary arterial hypertension (PAH) as indicated by elevated right heart/pulmonary artery systolic pressure (PASP >35 mm Hg)

Instructions

- **This form must be completed for all patients treated with FINTEPLA:**
  - Before the start of FINTEPLA treatment
  - With completion of each echocardiogram every 6 months for the duration of FINTEPLA treatment
  - With completion of echocardiogram performed 3 to 6 months after the final dose of FINTEPLA
- Submit the completed form online at www.FinteplaREMS.com, via fax to 1-833-568-6198, or via mail to 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134

PATIENT INFORMATION

*indicates required field

First Name*:	Last Name*:	
Date of Birth (MM/DD/YYYY)*:	Patient REMS ID:	
Address Line 1*:		
Address Line 2:		
City*:	State*:	ZIP Code*:
Height (cm)*:	Weight (kg)*:	BMI:

PRESCRIBER INFORMATION

*indicates required field

First Name*:	Last Name*:	
National Provider Identifier (NPI)*:	Prescriber REMS ID:	
Address Line 1*:		
Address Line 2:		
City*:	State*:	ZIP Code*:
Phone*:	Fax*:	Email:

FINTEPLA DOSING INFORMATION

Current dose of FINTEPLA: _____ mg/kg/day	Total: _____ mg/day	
Current duration of treatment with FINTEPLA:	Start Date (MM/DD/YYYY):	
	If patient is no longer on FINTEPLA, end date (MM/DD/YYYY):	

ECHOCARDIOGRAM RESULTS

*indicates required field

Date of echocardiogram (MM/DD/YYYY)*:

Regurgitation (check only 1 box per row)
If echocardiogram report states "mild to moderate" or "moderate to severe," check the more severe category.

Valve	Absent/Trace	Mild	Moderate	Severe
Aortic*	☐	☐	☐	☐
Mitral*	☐	☐	☐	☐

Elevated pulmonary arterial systolic pressure (PASP >35 mm Hg) (select one)* ☐ Yes ☐ No

Please provide PASP value: _____ mm Hg

Any other (ie, not detailed above) newly observed abnormality on echocardiogram (select one)* ☐ Yes ☐ No

Has a cardiovascular adverse event (CVAE) reporting form previously been submitted for this patient? ☐ Yes ☐ No

Have any of the previously reported abnormalities changed? ☐ Yes ☐ No

Authorization for Treatment

Is this patient authorized to receive FINTEPLA? (select one)* ☐ Yes ☐ No

If this patient is not authorized to receive FINTEPLA, please provide the reason(s) (select all that apply)*

☐ Changes in the echocardiogram or abnormal echocardiogram
☐ New diagnosis of VHD or PAH
☐ FINTEPLA already discontinued
☐ Noncompliance with echocardiogram
☐ Other (please specify) _____

If findings consistent with VHD, PAH, or any new abnormality have been reported on the echocardiogram, FINTEPLA REMS will send a follow-up *Cardiovascular Adverse Event Reporting Form* that must be completed and returned to the FINTEPLA REMS within 3 business days of receipt.

_____ **Signature*** _____ **Print Name** _____ **Date**

Submitted by*: ☐ Prescriber Delegate ☐ Prescriber

If you have any questions or need additional information, please visit www.FinteplaREMS.com or call 1-877-964-3649, Monday through Friday, between 7 AM and 7 PM Central Time.

Fintepla® (fenfluramine) 2.2 mg/mL oral solution