FINTEPLA Prescription Authorization and Patient Referral Form

Instructions

Please fax the following documents to Zogenix Central at 1-888-250-6103:

1. This *FINTEPLA Prescription Authorization and Patient Referral Form.*
2. A copy of all insurance cards (front and back). Ensure drug benefit card/information is included.
3. A copy of patient's clinical chart notes.

Patient or caregiver to sign section 3 of this form before submitting both pages.

Please fill out the fields below. All fields are required unless noted otherwise.

SECTION 1: PATIENT/INSURANCE INFORMATION

Patient Information

First Name:	Last Name:	Date of Birth (MM/DD/YYYY): / /	Gender:
Address Line 1:		Address Line 2 (optional):	
City:		State:	ZIP Code:
Home Phone #:	Work #:	Cell #:	Preferred Contact Number (optional): Home: ☐ Work: ☐ Cell: ☐
Best Time to Call (optional): ☐ Morning ☐ Midday ☐ Evening		Can We Leave a Message? ☐ Yes ☐ No	
Email (optional):		Preferred Language: ☐ English ☐ Spanish ☐ Other	
Caregiver Name:	Relationship to Patient:	Caregiver Phone # (if different from above):	

Insurance Information - Attach a copy (front and back) of patient's insurance card(s).

☐ Check if the patient does not have insurance.

Primary Insurance	Secondary Insurance (if available)
Primary Insurance Name:	Secondary Insurance Name (if available):
Phone #:	Phone #:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's Date of Birth (MM/DD/YYYY): / /	Policy Holder's Date of Birth (MM/DD/YYYY): / /
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:
Policy #: / Group #:	Policy #: / Group #:
Prescription Drug Insurer:	Prescription Drug Insurer:
Rx Phone #:	Rx Phone #:
Rx PCN #: / Rx BIN #:	Rx PCN #: / Rx BIN #:

SECTION 2: PRESCRIBER INFORMATION & PRESCRIPTION

This section will be completed by the doctor.

Prescriber Name:		Tax ID #:	
Address:		Name of Contact Person:	
NPI:	DEA:	Phone #:	Fax #:

Prescription (to be completed for all patients)

Drug: FINTEPLA (fenfluramine) 2.2 mg/mL oral solution, CIV			
Sig. Take:			mL Twice Daily:
Patient's Weight (kg):	Quantity:	Days' Supply:	Refills:
Special Instructions:			

Suggested Titration Schedule*

	Fenfluramine 2.2 mg/mL Oral Solution, CIV	Maximum Daily Dose
Starting Dose	0.10 mg/kg twice daily	26 mg
Day 7	0.20 mg/kg twice daily	26 mg
Day 14	0.35 mg/kg twice daily	26 mg

*If patient is taking stiripentol, see full Prescribing Information for dose adjustments and maximum dosage.

Diagnosis

☐ Seizures are associated with Dravet syndrome (DS) ☐ ICD-10 Code: _____ ☐ Other (please specify): _____

Describe how diagnosis was made (attach supporting documentation/test results): _____

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

☐ Divalproex ☐ Topiramate ☐ Clobazam ☐ Valproate/Valproic acid ☐ Other anticonvulsant(s) ☐ Epidiolex ☐ Stiripentol

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

Prescriber Agreement

By signing below, I certify the following:

1. The above therapy is medically necessary and in the best interest of the named patient.
2. I have received the appropriate permission from the patient (or the patient's legal representative).
3. 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 Zogenix Inc. and its agents.
4. 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 Zogenix Inc.'s agent and its employees to assist in getting coverage for this drug.
5. 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:** _____

(Stamped Signatures Are Not Valid) (Stamped Signatures Are Not Valid)

Print Name: _____ Date: / /

FINTEPLA New Patient Information (Note: To be completed by prescriber for new patient only or if the existing patient's information has changed. Patient must be enrolled in the FINTEPLA REMS Program prior to sending prescription.)
Please visit www.FinteplaREMS.com to download the *Patient Enrollment Form*.
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, you can always contact a Zogenix Central Care Coordinator for guidance.

SECTION 3: PATIENT AUTHORIZATION FOR ZOGENIX CENTRAL SUPPORT SERVICES

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

Required to enroll in Zogenix Central. 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 Zogenix Central and its representatives, agents, contractors, and affiliates (collectively, "Zogenix Inc.") in order for Zogenix Inc. to provide product support services.

I further authorize Zogenix 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 Zogenix Central 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 Zogenix Central 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 Zogenix 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 Zogenix 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 Zogenix Central 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 Zogenix Central.
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 Zogenix Central services, and, if I choose to cancel, I must do so in writing by sending notice of my cancellation to the following address: Zogenix Central, 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134. Zogenix Central 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 Zogenix 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 Zogenix Inc.

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

Name of Patient Representative: _____ Relationship to Patient: _____

Home Phone: _____ Mobile: _____

ZOGENIX

Fintepla®
(fenfluramine) Ⓒ
2.2 mg/mL oral solution