I. Medication Description

Fenfluramine and the metabolite, norfenfluramine, increase extracellular concentrations of serotonin through interaction with serotonin transporter proteins and exhibit agonist activity at serotonin 5HT-2 receptors. The precise mechanisms of action by which fenfluramine exerts its anticonvulsant effect are not known.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Fintepla is available when the following criteria have been met:
- Medication is prescribed by a neurologist AND
- Member is 2 years of age or older AND
- Medication is prescribed for the treatment of seizures associated with confirmed diagnosis of one of the following conditions:
  - Lennox-Gastaut syndrome:
    - Member has tried at least TWO of the following antiepileptic medications with treatment failure, unless contraindicated:
      - Valproic acid, lamotrigine, rufinamide, topiramate, felbamate, clobazam, ethosuximide, phenobarbital, levetiracetam, zonisamide, perampanel
  - Dravet syndrome:
    - Member has tried at least TWO of the following antiepileptic medications with treatment failure, unless contraindicated:
      - Clobazam, valproic acid, topiramate, stiripentol, levetiracetam, zonisamide, clonazepam, ethosuximide, phenobarbital

IV. Quantity Limitations

Coverage is available for up to 26 mg/day for allow for FDA approved dosing.

V. Coverage Duration
Initial coverage is provided for 6 months and may be renewed in up to 12 month increments.

VI. Coverage Renewal Criteria

Coverage can be renewed in 12-month increments based upon the following criteria:
- Member is responding positively to therapy

VII. Billing/Coding Information

Fintepla is available as 2.2 mg/mL oral solution in a 30 mL bottle

VIII. Summary of Policy Changes

- 12/15/20: new policy
- 5/28/21: Streamlined renewal criteria, increased coverage duration
- 8/1/22: added coverage for Lennox-Gaustat syndrome

IX. References
3. IPD Analytics, LLC. Accessed 05/2022.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.