Fintepla Prior Authorization with Quantity Limit Program Summary

This program applies to Medicaid.

The BCBS MN Step Therapy Supplement also applies for Medicaid.

Requests for an oral liquid form of a drug must be approved if BOTH of the following apply:

1) the indication is FDA labeled AND

2) the patient is using an enteral tube for feeding or medication administration

POLICY REVIEW CYCLE

Effective Date	Date of Origin
06-01-2024	01-01-2021

FDA LABELED INDICATIONS AND DOSAGE

Agent(s)	FDA Indication(s)	Notes	Ref#
Fintepla® (fenfluramine) Oral solution	Treatment of seizures associated with Dravet syndrome (DS) and Lennox-Gastaut syndrome (LGS) in patients 2 years of age and older		1

See package insert for FDA prescribing information: https://dailymed.nlm.nih.gov/dailymed/index.cfm

CLINICAL RATIONALE

Dravet Syndrome	Dravet syndrome (DS) is a severe form of epilepsy with an onset of recurrent, prolonged seizures in infancy that are often triggered by fever or overheating. DS is characterized by lifelong comorbidities, including neurodevelopmental problems and intellectual disability.(2,3,4,9) Mutations in the alpha-1 subunit of the voltage-gated sodium channel (SCN1A) gene are identified in at least 80% of patients with DS.(2,3,9) Status epilepticus is common and is one of the leading causes of premature mortality seen with DS. Patients with DS have an elevated risk of premature mortality, with the most common cause being sudden unexpected death in epilepsy (SUDEP).(2,3,4) Other types of seizures appear before age 5 years and include myoclonic, focal, and atypical absence seizures.(2,3,9) Valproate is considered first-line therapy, with clobazam added if needed.(2,3,4,9) Additional agents include stiripentol, topiramate, cannabidiol, and fenfluramine.(3,4,9) For patients with symptoms refractory to drug therapy, ketogenic diet and vagal nerve stimulation may be beneficial.(2,3,4,9)
Lennox-Gastaut Syndrome	Lennox-Gastaut syndrome (LGS) is a severe form of epilepsy involving several seizure types, with an onset during infancy or early childhood. Many causes of LGS have been identified, including genetic disorders, trauma, cortical malformations, perinatal hypoxia, and meningitis. Tonic, atonic, and atypical absence seizures are the most common seizure types associated with LGS. Clinical features that may be present include cognitive dysfunction, behavioral abnormalities, and neurodevelopmental impairment. Management of LGS is difficult because it is refractory to many treatments, and no specific therapy is effective for all patients. Valproate is generally considered first-line therapy, and if monotherapy is ineffective another drug such as lamotrigine or rufinamide is added to valproate therapy.(7,8) Alternative adjunctive antiseizure medications include topiramate, clobazam, cannabidiol, fenfluramine, or

	felbamate.(8) Additional therapies, for patients who do not respond to antiseizure medications, include the ketogenic diet and vagal nerve stimulation.(7,8)
Efficacy	The effectiveness of fenfluramine for the treatment of seizures associated with Dravet syndrome in patients 2 years of age and older was established in two randomized, double-blind, placebo-controlled trials in patients 2 to 18 years of age. Study 1 (N = 117) compared a 0.7 mg/kg/day and a 0.2 mg/kg/day dose of fenfluramine with placebo in patients who were NOT receiving stiripentol. Study 2 (N = 85) compared a 0.4 mg/kg/day dose of fenfluramine with placebo in patients who were receiving stiripentol and either clobazam, valproate, or both. In both studies, patients had a clinical diagnosis of Dravet syndrome and were inadequately controlled on at least one antiepileptic drug (AED) or other antiseizure treatment including vagal nerve stimulation or a ketogenic diet. In Study 1, 98% of patients were taking 1-4 concomitant AEDs; in Study 2, 100% were taking 2-4 concomitant AEDs.(1) The primary efficacy endpoint in both studies was the change from baseline in the frequency of convulsive seizures per 28 days during the treatment period. For Study 1, the percent reduction in monthly convulsive seizure frequency was 70% for the 0.7 mg/kg/day dose (p less than 0.001) and 31.7% for the 0.2 mg/kg/day dose (p=0.043); for Study 2 it was 59.5% reduction (p less than 0.001). A reduction in convulsive seizures was observed within 3-4 weeks of starting fenfluramine, and the effect remained generally consistent over the 14- or 15-week treatment period.(1) A secondary endpoint was longest seizure-free interval, for which the median longest seizure-free intervals in the 0.7 mg/kg/day, 0.4 mg/kg/day, and 0.2 mg/kg/day groups were 25 days, 22 days, and 15 days, respectively.(5,6) The effectiveness of fenfluramine for the treatment of seizures associated with LGS in patients 2 years of age and older was established in a randomized, double-blind, placebo-controlled trial in patients 2 to 35 years of age. Study 3 (N=263) compared a 0.7 mg/kg/day and a 0.2 mg/kg/day dose of fenfluramine with placebo in patients with a diagnosis of LGS who were inadequately controlled on at least one antiepileptic drug (AED) or other antiseizure treatment including vagal nerve stimulation and/or a ketogenic diet.(1) The primary efficacy endpoint was the median percent change from baseline (reduction) in the frequency of seizures per 28 days during the treatment period. The median percent change from baseline (reduction) in the frequency of seizures per 28 days was significantly greater for the 0.7 mg/kg/day group compared with placebo (23.7%; p=0.0037). The effect remained generally consistent over the 14-week treatment period.(1)
Safety	Fintepla carries a boxed warning for valvular heart disease and pulmonary arterial hypertension. There is an association between serotonergic drugs with 5-HT2B receptor agonist activity, including fenfluramine, and valvular heart disease and pulmonary arterial hypertension. Echocardiogram assessments are required before, during, and after treatment with Fintepla; benefits versus risks of initiating or continuing must be considered based on echocardiogram findings. Because of these risks, Fintepla is available only through the Fintepla REMS program.(1) Fintepla has the following contraindications:(1) • Concomitant use of, or within 14 days of the administration of, monoamine oxidase inhibitors because of an increased risk of serotonin syndrome. • Hypersensitivity to fenfluramine or any of the excipients in Fintepla.

REFERENCES

Number	Reference
1	Fintepla prescribing information. Zogenix, Inc. December 2023.

Number	Reference
2	Wirrell EC, Laux L, Donner E, et al. Optimizing the Diagnosis and Management of Dravet Syndrome: Recommendations from a North American Consensus Panel. Pediatr Neurol. 2017;68:18-34.
3	Sullivan J, Knupp K, Wirrell E, et al. Dravet Syndrome. National Organization for Rare Disorders (NORD). Last updated July 2020. Available at https://rarediseases.org/rare-diseases/dravet-syndrome-spectrum/.
4	Andrade DM, Nascimento FA, et al. Dravet Syndrome: Management and Prognosis. UpToDate. Last updated November 2022. Literature review current through December 2023.
5	Lagae L, Sullivan J, Knupp K, et al. Fenfluramine Hydrochloride for the Treatment of Seizures in Dravet Syndrome: A Randomized, Double-Blind, Placebo-Controlled Trial. Lancet. 2019;394(10216):2243-2254.
6	Nabbout R, Mistry A, Zuberi S, et al. Fenfluramine for Treatment-Resistant Seizures in Patients with Dravet Syndrome Receiving Stiripentol-Inclusive Regimens: A Randomized Clinical Trial. JAMA Neurol. 2020;77(3):300-308.
7	Wheeless JW. Lennox-Gastaut Syndrome. National Organization for Rare Disorders (NORD). Last updated June 2020. Available at https://rarediseases.org/rare-diseases/lennox-gastaut-syndrome/.
8	Wilfong A, et al. Lennox-Gastaut syndrome. UpToDate. Last updated June 2023. Literature review current through December 2023.
9	Wirrell E, Hood V, Knupp KG, et al. International consensus on diagnosis and management of Dravet syndrome. Epilepsia. 2022;63(7):1761-1777.

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Fintepla	fenfluramine hcl oral soln	2.2 MG/ML	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Fintepla	Fenfluramine HCl Oral Soln 2.2 MG/ML	2.2 MG/ML	360	mLs	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Fintepla	fenfluramine hcl oral soln	2.2 MG/ML	Medicaid

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Fintepla	Fenfluramine HCl Oral Soln 2.2 MG/ML	2.2 MG/ML	Medicaid

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Initial Evaluation **Target Agent(s)** will be approved when ONE of the following is met: 1. ALL of the following: A. ONE of the following: 1. BOTH of the following: A. ONE of the following 1. The patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days **OR** 2. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed **AND** B. The patient has an FDA labeled indication for the requested agent **OR** 2. BOTH of the following: A. ONE of the following: 1. If the patient has a diagnosis of Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS), then ONE of the following: A. The requested agent is a preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) **OR** B. The request is for a non-preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) and ONE of the following: 1. The patient is currently being treated with the requested agent and is experiencing a positive therapeutic outcome AND the prescriber provides documentation that switching the member to a preferred drug is expected to cause harm to the member or that the preferred drug would be ineffective **OR** 2. The patient has tried and had an inadequate response to two preferred chemically unique agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) as indicated by BOTH of the following: A. ONE of the following: 1. Evidence of a paid claim(s) **OR** 2. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) **AND** B. ONE of the following: 1. The required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event **OR** 2. The prescriber has submitted an evidence-

Module	Clinical Criteria for Approval
	based and peer-reviewed clinical practice guideline supporting the use of the requested agent over the prerequisite/preferred agent(s) **OR** 3. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) that is not expected to occur with the requested agent **OR** 4. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **OR** 5. The prescriber has submitted documentation supporting the use of the non-preferred agent over the preferred agent(s) **OR** 2. The patient has another FDA labeled indication for the requested agent and route of administration **AND** B. If the patient has an FDA labeled indication, then ONE of the following: 1. The patient's age is within FDA labeling for the requested indication for the requested agent **OR** 2. There is support for using the requested agent for the patient's age for the requested indication **AND** B. If the patient has a diagnosis of seizure associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS), the requested agent will NOT be used as monotherapy for seizure management **AND** C. An echocardiogram assessment will be obtained before and during treatment with the requested agent to evaluate for valvular heart disease and pulmonary arterial hypertension **AND** D. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** E. The patient does NOT have any FDA labeled contraindications to the requested agent **OR** 2. If the request is for an oral liquid form of a medication, then BOTH of the following: A. The patient has an FDA labeled indication **AND** B. The patient uses an enteral tube for feeding or medication administration **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria. **Renewal Evaluation** **Target Agent(s)** will be approved when BOTH of the following are met:

Module	Clinical Criteria for Approval
	1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] **AND** 2. ONE of the following: 1. ALL of the following: A. The patient has had clinical benefit with the requested agent **AND** B. If using for seizure management associated with Dravet syndrome (DS) or Lennox-Gastaut syndrome (LGS), the requested agent will NOT be used as monotherapy **AND** C. An echocardiogram assessment will be obtained during treatment with the requested agent, to evaluate for valvular heart disease and pulmonary arterial hypertension **AND** D. The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis **AND** E. ONE of the following: 1. The requested agent is a preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) **OR** 2. The request is for a non-preferred agent in the Minnesota Medicaid Preferred Drug List (PDL) and ONE of the following: A. The patient is currently being treated with the requested agent and is experiencing a positive therapeutic outcome AND the prescriber provides documentation that switching the member to a preferred drug is expected to cause harm to the member or that the preferred drug would be ineffective **OR** B. The patient has tried and had an inadequate response to two preferred chemically unique agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) as indicated by BOTH of the following: 1. ONE of the following: A. Evidence of a paid claim(s) **OR** B. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) **AND** 2. ONE of the following: A. The required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event **OR** B. The prescriber has submitted an evidence-based and peer-reviewed clinical practice guideline supporting the use of the requested agent over the prerequisite/preferred agent(s) **OR** C. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to the preferred agents within the same drug class in the Minnesota Medicaid Preferred Drug List (PDL) that is not expected to occur with the requested agent **OR** D. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm **OR** E. The prescriber has submitted documentation supporting the use of the non-preferred agent over the preferred agent(s) **AND** F. The patient does NOT have any FDA labeled contraindications to the requested agent **OR**

Module	Clinical Criteria for Approval
	2. If the request is for an oral liquid form of a medication, then BOTH of the following: A. The patient has an FDA labeled indication **AND** B. The patient uses an enteral tube for feeding or medication administration **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity limit for the Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. ALL of the following: A. The requested quantity (dose) exceeds the program quantity limit **AND** B. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** C. The requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit **Length of Approval:** up to 12 months