Mass General Brigham
Health Plan

Fintepla (fenfluramine)
Effective 11/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Fintepla (fenfluramine) is indicated for the treatment of seizures associated with Dravet syndrome and Lennox-Gastaut syndrome in patients 2 years of age and older.

Coverage Guidelines
Authorization may be granted for members who are new to the plan within the past 90 days currently receiving treatment with requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when all of the following diagnosis-specific criteria are met:

Dravet Syndrome
1. Member has a diagnosis of seizures associated with Dravet Syndrome (DS)
2. Member is 2 years of age or older
3. Requested medication is prescribed by or in consultation with a neurologist
4. Member has had an inadequate response or adverse reaction to at least 2 of the following anticonvulsant agents **OR** a contraindication to ALL of the following agents:
    a. Clobazam
    b. Clonazepam
    c. Ethosuximide
    d. Levetiracetam
    e. Phenobarbital
    f. Stiripentol
    g. Topiramate
    h. valproic acid
    i. Zonisamide

Lennox-Gastaut Syndrome
1. Diagnosis of Lennox-Gastaut Syndrome
2. Member is 2 years of age or older
3. Requested medication is prescribed by or in consultation with a neurologist

4. Member has had an inadequate response or adverse reaction to at least 2 of the following anticonvulsant agents OR a contraindication to all of the following agents:
    a. clobazam
    b. felbamate
    c. lamotrigine
    d. topiramate
    e. valproic acid

Continuation of Therapy

Requests for reauthorization will be approved when all of the following criteria are met:

1. Documentation member has had a positive response to therapy (e.g., decrease in number or frequency of seizures member is experiencing)

Limitations

1. Initial approvals will be granted for 3 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Drug Name and Dosage Form	Quantity Limit
Fintepla oral solution	12 mL per day

References

1. Fintepla (fenfluramine) [prescribing information]. Smyrna, GA: UCB Inc; April 2025.

Review History

09/16/2020 – Created and Reviewed Sept P&T Mtg. Effective 11/01/20.
11/16/2022 – Reviewed for Nov P&T. Separated out MH vs Comm/Exch. No clinical changes.
11/15/2023 – Reviewed and Updated for Nov P&T; Added indication of Lennox Gastaut syndrome. Effective 1/1/2024.
08/13/2025 – Reviewed and updated at August P&T. Updated language for members who are new to the Plan. Updated verbiage for specialist prescriber. Updated criteria for LGS to remove requirement that Fintepla will be used as adjunctive treatment. Updated reauthorization criteria to require documentation of a positive response to therapy. Effective 11/01/2025.