

# Prescription Authorization and Patient Referral (PAPR) Form

Please complete all fields and **fax the form and attachments to 1-888-250-6103** or submit the form and attachments on the Provider Portal ([ONWARDProviderPortal.com](http://ONWARDProviderPortal.com)). Patient's prescription cannot be processed until a REMS Patient Enrollment Form has been submitted. For more information, visit [FinteplaREMS.com](http://FinteplaREMS.com).

SECTION 1: PATIENT INFORMATION

Patient First Name:		Patient Last Name:		Date of Birth (MM/DD/YYYY): / /		Gender:
Address:						
City:				State:		ZIP Code:
Patient Mobile Phone: - -		Patient Home Phone: - -		Patient Email Address:		
Authorized Patient Representative Name:				Relationship of Authorized Patient Representative to Patient:		
Authorized Patient Representative Phone: - - <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Work				Best Time to Call (optional): <input type="checkbox"/> Morning <input type="checkbox"/> Midday <input type="checkbox"/> Evening		
Can We Leave a Message? <input type="checkbox"/> Yes <input type="checkbox"/> No				Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Authorized Patient Representative Email Address:						
Does the patient reside in a Long-Term Care, IDD, or Group Home Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No				If Yes, Facility Name:		
Facility Contact Name:				Facility Contact Phone: - -		
Facility Contact Email:						

Authorized patient representative may be a caregiver, legal guardian, power of attorney, etc.

**Attach a copy (front and back of insurance card[s])**

Primary Insurance Name:			Secondary Insurance Name:		
Phone: - -			Phone: - -		
Policy Holder's Name:			Policy Holder's Name:		
Policy #:		Group #:	Policy #:		Group #:
RXBIN #:	RXPCN #:	RXGRP #:	RXBIN #:	RXPCN #:	RXGRP #:

SECTION 2: PRESCRIBER INFORMATION & PRESCRIPTION

Prescriber Name:		Tax ID #:		NPI:	
Facility Name:			Facility Address:		
City:			State:		ZIP Code:
Name of Contact Person:				Email: <input type="checkbox"/> Preferred	
Phone: - - <input type="checkbox"/> Preferred		Fax: - - <input type="checkbox"/> Preferred		ONWARD Portal: <input type="checkbox"/> Preferred	

**Prescription**

Drug: FINTEPLA (fenfluramine) 2.2 mg/mL oral solution	
Patient's Weight: _____ kg	Gastric Feeding Tube <input type="checkbox"/> Yes <input type="checkbox"/> No
Sig. Take _____ mL (round to the nearest tenth) PO BID for _____ days, Take _____ mL (round to the nearest tenth) PO BID for _____ days, Take _____ mL (round to the nearest tenth) PO BID thereafter	
Special Instructions:	
Quantity (based on maintenance dose): _____ mL Days' Supply: _____ Refills: _____	

**Suggested Titration Schedule\***

	Weight-based dosing <sup>†</sup>	Calculated Dose Examples for Patients Weighing:		
		22 kg	44 kg	66 kg
<b>Initial Dose</b>	0.1 mg/kg BID	1 mL BID	2 mL BID	3 mL BID
<b>Titration Dose (Day 7)</b>	0.2 mg/kg BID	2 mL BID	4 mL BID	5.9 mL BID
<b>Maintenance Dose (Day 14)</b>	0.35 mg/kg BID	3.5 mL BID	5.9 mL BID	5.9 mL BID
<b>Maximum total daily dose mg: 26 mg* (13 mg BID)</b>		<b>Maximum total daily dose mL: 11.8 mL* (5.9 mL BID)</b>		

\*If patient is taking stripentol or a strong CYP1A2 or CYP2D6 inhibitor; has severe renal impairment; or has mild, moderate, or severe hepatic impairment, see full Prescribing Information for dose adjustments and maximum dosage.

<sup>†</sup>To calculate: Weight (kg) × dosage (mg/kg) ÷ 2.2 mg/mL = mL dose BID.

**Diagnosis (Attach documentation and test results to describe how the diagnosis was made.)**

<b>ICD-10 Code:</b>		<input type="checkbox"/> G40.81 (LGS)
<input type="checkbox"/> G40.83 (DS); Polymorphic epilepsy in infancy (PMEI); Severe myoclonic epilepsy in infancy (SMEI)		<input type="checkbox"/> G40.813 (LGS) intractable, with status epilepticus
<input type="checkbox"/> G40.833 (DS) intractable, with status epilepticus		<input type="checkbox"/> G40.814 (LGS) intractable, without status epilepticus
<input type="checkbox"/> G40.834 (DS) intractable, without status epilepticus		<input type="checkbox"/> G40.811 (LGS) not intractable, with status epilepticus
<input type="checkbox"/> Other ICD-10 Code (unrelated to DS or LGS): _____		<input type="checkbox"/> G40.812 (LGS) not intractable, without status epilepticus

**Patient's Echocardiogram**

Patient's echocardiogram has been scheduled and/or completed: Yes No **If yes:** Patient's echocardiogram appointment date: / /

If the patient/caregiver has decided where they would like to obtain the required echocardiogram, please indicate where:

Hospital-based facility    Outpatient imaging center    At home\*    LTC facility    Undecided    Other: \_\_\_\_\_

\*Patients participating in UCB's At-home Echo Program must affirmatively opt in through ONWARD and agree to comply with the Program's terms and conditions. **For participating patients, an echo order will need to be faxed to ONWARD at 1-888-250-6103.**

**Prescriber Agreement**

By signing below, I certify: 1) The therapy is medically necessary and that this information is accurate to the best of my knowledge; 2) I am disclosing this information to UCB, their affiliates, agents, representatives, business partners, and service providers (together "UCB") to help enable treatment for this Patient; 3) The Patient is aware of, has consented to, and has directed my disclosure of their information to UCB so that UCB may contact the Patient to further enable services for those purposes and that such consent and direction applies to disclosures made through the duration of the Patient's therapy; 4) I will not seek reimbursement from any third party for the support UCB provides; and 5) I am licensed to prescribe the prescription medication identified in this form, the prescription complies with my state-specific prescribing requirements, and I appoint UCB as my agent for the limited purposes of conveying this prescription by any means under applicable law only to the dispensing pharmacy. I understand that by signing this form, I am requesting support from UCB for Patients receiving FINTEPLA<sup>®</sup>. **PRESCRIBER SIGNATURE: PRESCRIBER MUST MANUALLY SIGN AND DATE. RUBBER STAMPS AND SIGNATURE BY OTHER OFFICE PERSONNEL FOR THE PRESCRIBER WILL NOT BE ACCEPTED.**



**Dispense as Written:** \_\_\_\_\_

**Substitution Allowed:** \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: / / \_\_\_\_\_

➔ This section to be completed and signed by new patient or authorized patient representative.

**Required to enroll in ONWARD Support Program. 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 ONWARD and its representatives, agents, contractors, and affiliates (collectively, "UCB, Inc.") in order for UCB, Inc. to provide product support services.

I further authorize UCB, 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 ONWARD 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, or telephone. I confirm that I am the subscriber for the mobile telephone number(s) provided, and I agree to notify ONWARD promptly if any of my numbers change in the future. I additionally consent to receive commercial email messages, letters, and/or educational resources from UCB, Inc.; conduct market analyses/research or other commercial activity, including aggregating my Protected Health Information with other data for such analyses; assist with analysis related to quality, efficacy, and safety for UCB medication; and de-identify my Protected Health Information for use for any purpose under applicable law.

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 UCB, 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, that will not affect my treatment (including the receipt of UCB medication), but I will not be eligible to join ONWARD 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 ONWARD. 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 ONWARD services, and, if I choose to cancel, I must do so by calling ONWARD at 1-888-964-3649, or in writing by sending notice of my cancellation to the following address: ONWARD, 1710 N Shelby Oaks Dr, Ste 3, Memphis, TN 38134. ONWARD 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 UCB, Inc. This Authorization will remain in effect for 5 years from the date of signature, unless a shorter time period is required by applicable state law, or you withdraw your consent earlier as described in the UCB Privacy Policy.

By checking here, you agree to receive text messages (such as refill reminders, shipping tracking numbers, echocardiogram schedules) from UCB, Inc. for patient support. Message and data rates may apply. Message frequency will vary based on need. I understand I can opt out of future text messages by replying "STOP" to any text message received. If you have questions or require help, call 1-888-964-3649. For more information on how UCB will use your information, please view our privacy policy at [www.ucb-usa.com/policy](http://www.ucb-usa.com/policy) and our text messaging terms and conditions at [www.ucbONWARD.com/Text-Terms-Conditions](http://www.ucbONWARD.com/Text-Terms-Conditions).

Marketing Consent (Optional): By checking here and providing your information, you acknowledge you are a U.S. resident and give UCB and its business partners permission to send you information or contact you and/or your healthcare provider regarding your disease as well as information on other related treatments, products and services, and for marketing and informational purposes by phone, email, or mail. You understand that UCB or its business partners will not sell your name, address, email address, or any other information to another party for their own marketing use.

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

➔ Patient or Authorized Patient Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**I, the patient or authorized patient representative, authorize the following individual to act as my additional representative. This individual has my full permission to obtain and disclose personal health information to UCB, Inc.**

Name of Additional Authorized Patient Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Additional Authorized Patient Representative Phone: \_\_\_\_\_  Home  Mobile  Work