

## **Clinical Policy: Fenfluramine (Fintepla)**

Reference Number: CP.PMN.246

Effective Date: 09.01.20

Last Review Date: 05.22

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Fenfluramine (Fintepla<sup>®</sup>) is a serotonin transporter protein modulator and exhibits agonist activity at serotonin 5HT-2 receptors.

### **FDA Approved Indication(s)**

Fintepla is indicated for the treatment of seizures associated with Dravet syndrome (DS) in patients 2 years of age and older.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Fintepla is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Dravet Syndrome (must meet all):**

1. Diagnosis of DS;
2. Prescribed by or in consultation with a neurologist;
3. Age  $\geq$  2 years;
4. Will be used as adjunctive therapy (*see Appendix B*) with at least one other antiepileptic drug;
5. Failure of  $\geq$  3 month trial of Epidiolex<sup>®</sup> at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed either of the following (a or b):
  - a. Members not on concomitant Diacomit<sup>®</sup>: 26 mg (12 mL) per day;
  - b. Members on concomitant Diacomit plus clobazam: 17 mg (8 mL) per day.

##### **Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

##### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Dravet Syndrome** (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Fintepla for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Fintepla will continue to be used as adjunctive therapy (*see Appendix B*) with at least one other antiepileptic drug;
4. If request is for a dose increase, new dose does not exceed either of the following (a or b):
  - a. Members not on concomitant Diacomit: 26 mg (12 mL) per day;
  - b. Members on concomitant Diacomit plus clobazam: 17 mg (8 mL) per day.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

**B. Other diagnoses/indications** (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 12 months (whichever is less); or**

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

DS: Dravet syndrome

FDA: Food and Drug Administration

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
Diacomit <sup>®</sup> (stiripentol)	50 mg/kg/day PO in 2-3 divided doses	50 mg/kg/day
Epidiolex <sup>®</sup> (cannabidiol)	Initial: 2.5 mg/kg PO BID Maintenance: 5 mg/kg PO BID	20 mg/kg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
clobazam (Onfi <sup>®</sup> , Sympazan <sup>®</sup> )*	Initial: 0.2-0.3 mg/kg/day PO*	0.5-2 mg/kg/day
valproic acid (Depakene <sup>®</sup> , Depakote <sup>®</sup> , Stavzor <sup>®</sup> )*	Initial: 10-15 mg/kg/day PO, given in 2-3 equally divided doses*	25-60 mg/kg/day
topiramate (Topamax <sup>®</sup> , Trokendi <sup>®</sup> XR, Qudexy <sup>®</sup> XR)*	Initial: 0.5-2 mg/kg/day PO*	8-12 mg/kg/day
levetiracetam (Spritam <sup>®</sup> , Keppra <sup>®</sup> )*	Initial: 10-20 mg/kg/day PO, divided in 2-3 doses*	60-80 mg/kg/day
Other antiepileptic drugs: * clonazepam (Klonopin <sup>®</sup> ), zonisamide (Zonegran <sup>®</sup> ), ethosuximide (Zarontin <sup>®</sup> ), phenobarbital	PO; off-label dosing information not available	Off-label dosing information not available

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

\*Off-label

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): hypersensitivity to fenfluramine or any of the excipients in Fintepla, concomitant use of, or within 14 days of the administration of monoamine oxidase inhibitors because of an increased risk of serotonin syndrome
- Boxed warning(s): valvular heart disease, pulmonary arterial hypertension

*Appendix D: General Information*

- Complete seizure control is typically not achievable in DS, so the primary goal of therapy is to reduce seizure frequency. The following therapies are recommended for the management of DS by a North American consensus panel (January 2017):

	North American Consensus Panel
1 <sup>st</sup> line	Valproic acid or clobazam <i>If first choice is not effective, then add the other</i>
2 <sup>nd</sup> line	Addition of Diacomit or topiramate
3 <sup>rd</sup> line	Addition of clonazepam, levetiracetam, zonisamide, ethosuximide, or phenobarbital

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
DS	Initial starting and maintenance dose: 0.1 mg/kg PO BID, which can be increased weekly based on efficacy and tolerability.	No concomitant Diacomit: 26 mg/day  Concomitant Diacomit and clobazam: 17 mg/day

**VI. Product Availability**

Oral solution: 2.2 mg/mL

**VII. References**

1. Fintepla Prescribing Information. Emeryville, CA: Zogenix Inc.; June 2020. Available at: [www.Fintepla.com](http://www.Fintepla.com). Accessed April 19, 2021.
2. Wirrell EC, Laux L, Jette N, et al. Optimizing the diagnosis and management of Dravet syndrome: recommendations from a North American consensus panel. *Pediatr Neurol.* 2017; 68: 18-34.
3. Micromedex<sup>®</sup> Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 19, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.14.20	08.20
Per November SDC and prior clinical guidance, added redirection to Epidiolex.	11.11.20	
3Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	04.19.21	08.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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