

**BRINEURA (cerliponase alfa) PRIOR AUTHORIZATION FORM**

Prior authorization guidelines and quantity limits are located in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Brineura** accessible on the Department’s Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact’s phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

**CLINICAL INFORMATION**

<b>Medication:</b> Brineura injection kit	<b>Quantity:</b> <input type="checkbox"/> 1 kit <input type="checkbox"/> other: _____ kits	<b>Refills:</b>
<b>Directions:</b> <input type="checkbox"/> 300 mg (1 kit) every other week <input type="checkbox"/> other: _____		
<b>Diagnosis:</b>	<b>Dx code (required):</b>	

**INITIAL REQUESTS**

1. Does the recipient have a diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) documented by a TPP1 enzyme activity test or TPP1/CLN2 molecular test?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of Brineura for the recipient’s diagnosis.</i>
2. Is Brineura prescribed by or in consultation with a pediatric neurologist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation with a specialist, if applicable.</i> <input type="checkbox"/> No
3. Did the recipient have a baseline CLN2 Clinical Rating Scale score?	<input type="checkbox"/> Yes <i>Submit documentation of baseline evaluation and assessment.</i> <input type="checkbox"/> No
4. Does the recipient have any contraindications to Brineura? <i>Check all that apply.</i> <input type="checkbox"/> acute intraventricular access device-related complications <input type="checkbox"/> has a ventriculoperitoneal shunt	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

**RENEWAL REQUESTS**

1. Is Brineura prescribed by or in consultation with a pediatric neurologist?	<input type="checkbox"/> Yes <i>Submit documentation of consultation with specialist, if applicable.</i> <input type="checkbox"/> No
2. Did the recipient have a repeat CLN2 Clinical Rating Scale score?	<input type="checkbox"/> Yes <i>Submit documentation of evaluation and assessment.</i> <input type="checkbox"/> No
3. Is the recipient experiencing clinical benefit from Brineura?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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