

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.*

Drug Requested: **Brineura™** (cerliponase alfa) (J3590, C9399) **(Medical)**

DRUG INFORMATION: *Complete all information below or authorization process will be delayed.*

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSAGE: 300 mg once every other week given by intraventricular (ICV) infusion

- Following administration, member **MUST** also receive intraventricular electrolyte infusion

CLINICAL CRITERIA: **All** boxes that apply **must** be checked to ensure the authorization process will **NOT** be delayed.

For initial 12 month approval, ALL of the following criteria MUST be met (chart notes and labs MUST be submitted for documentation of criteria):

- Member must be 3 years of age or older, **AND**
- Member must have a documented diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency and Jansky-Bielschowski disease **AND**
- Diagnosis of CLN2 must have been confirmed by TPP1 deficiency or the detection of pathogenic mutations in each allele of the TPP1 gene (also known as the CLN2 gene) **AND**
- Member is symptomatic **AND**
- Member does not have acute intraventricular access device-related complications (i.e. leakage, device failure, or device-related infection) or a ventriculoperitoneal shunt
- Approval duration will be for 12 months

For continued 12 month approval (chart notes MUST be submitted for documentation):

- Member must demonstrate that ambulation loss has slowed from baseline
- Reauthorization approval duration of 12 months

(signature block on next page)

Medication being provided by (check applicable box below):

Location/site of drug administration: _____

NPI or DEA # of administering location: _____

OR

Specialty Pharmacy: PropriumRx

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018