OPTIMA HEALTH COMMUNITY CARE

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 1-844-348-3720. 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 INFORMATON: ***Complete information below. If incomplete, 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. Incomplete information will delay the authorization process.***

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: ~~4/6/2018~~ ; **5/25/2018**