OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-202-5034. 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™ IV(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 qualify to ensure 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

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**: **Briova SpecialtyRx**

(signature on next page)

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 11/16/2017
REVISED/UPDATED: ~~3/28/2018;~~ **7/10/2018**