

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

BRINEURA

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Brineura® (cerliponase alfa)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member between 3 to 16 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member seen and followed by a neurologist/pediatric neurologist who is familiar with treatment of Batten disease?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a documented diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 confirmed by TPP1 deficiency and/or a dysfunctional mutation of the TTP1 gene on chromosome 11p15?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does documentation show a two-domain score of 3 to 6 on motor and language domains of the Hamburg CLN2 Clinical Rating Scale, with a score of at least 1 in each of these domains at the time of request?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the member ambulatory?	<input type="checkbox"/>	<input type="checkbox"/>	

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member meet initial authorization criteria?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member experienced unacceptable toxicity to the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Have CSF testing within the past 3 months been documented?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had a clinically significant response to the therapy with a stability/lack of decline in motor	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

function/milestones on the motor domain of the Hamburg CLN2 Clinical Rating Scale?			
6. Has the member had a 12-lead ECG performed within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-CHIP-M014
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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