HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
BRINEURA

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans 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: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213

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?	☐	☐	
2. Is the member seen and followed by a neurologist/pediatric neurologist who is familiar with treatment of Batten disease?	☐	☐	
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?	☐	☐	**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?	☐	☐	**Please provide documentation**
5. Is the member ambulatory?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet initial authorization criteria?	☐	☐	
3. Has the member experienced unacceptable toxicity to the therapy?	☐	☐	**Please provide documentation**
4. Have CSF testing within the past 3 months been documented?	☐	☐	**Please provide documentation**
5. Has the member had a clinically significant response to the therapy with a stability/lack of decline in motor	☐	☐	**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?	☐	☐	**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- M014
Origination Date: 10/08/2018
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023