SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

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

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

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

- Following administration, member must also receive intraventricular electrolyte infusion

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval – 12 months

❑ Member must be 3 years of age or older

AND

(Continued on next page)

- ❑ 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

Reauthorization/Continued Approval - 12 months. To qualify, documentation must be submitted.

- ❑ Member must demonstrate that ambulation loss has slowed from baseline

AND

- ❑ Reauthorization approval duration of 12 months

Medication being provided by (check box below that applies):

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****

REVISED/UPDATED/REFORMATTED: ~~4/6/2018; 5/25/2018; 8/17/2018; 10/8/2018; 2/4/2019; 7/22/2019; 10/16/2019;~~ **10/16/2020**