pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BRINEURA (cerliponase alfa) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Brineura** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested: Brineura injection kit	Quantity: ☐1 kit ☐other: ______ kits	Refills:
Directions: ☐300 mg (1 kit) every other week ☐other:		
Diagnosis:	Dx code (*required*):	

SPECIALTY PHARMACY DRUG PROGRAM: Brineura is included in the DHS Specialty Pharmacy Drug Program and is available from DHS's specialty pharmacy. Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Specialty-Pharmacy-Program.aspx for more information about the Specialty Pharmacy Drug Program.	**DHS specialty pharmacy:** Chartwell Pennsylvania, LP Oakdale, PA Phone: 833-710-0211 Fax: 412-920-1869 www.chartwellpa.com
Is Brineura prescribed by or in consultation with a pediatric neurologist?	☐Yes ☐No *Submit documentation of consultation with specialist, if applicable.*
INITIAL Requests	
Does the beneficiary have a diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) documented by a TPP1 enzyme activity test or TPP1/CLN2 molecular test?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of Brineura for the beneficiary's diagnosis.*
Does the beneficiary have a baseline CLN2 Clinical Rating Scale score?	☐Yes ☐No *Submit documentation of baseline evaluation and assessment.*
Does the beneficiary have any contraindications to Brineura? *Check all that apply.* ☐acute intraventricular access device-related complications ☐has a ventriculoperitoneal shunt	☐Yes ☐No *Submit documentation.*
RENEWAL Requests	
Does the beneficiary have a repeat CLN2 Clinical Rating Scale score?	☐Yes ☐No *Submit documentation of evaluation and assessment.*
Is the beneficiary experiencing clinical benefit from Brineura?	☐Yes ☐No *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:

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