JOHNS HOPKINS
HEALTH PLANS

Brineura

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) (also known as tripeptidyl peptidase 1 (TPP1) deficiency) (*If checked, go to 2*)

❒ Other, please specify. _____ (*If checked, go to 2*)

2. Is this a request for continuation of therapy with the requested medication?

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 Brineura SGM 1831-A – 08/2023.

❒ Yes, *Continue to 3*
❒ No, *Continue to 5*

3. Has the patient experienced no loss of ambulation or a slowed loss of ambulation from baseline?

❒ Yes, no loss of ambulation (*If checked, go to 4*)

❒ Yes, slowed loss of ambulation (*If checked, go to 4*)

❒ No (*If checked, go to 4*)

4. Does the patient have intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. Was the diagnosis confirmed by either an enzyme assay demonstrating a deficiency of tripeptidyl peptidase 1 (TPP1) enzyme activity OR by genetic testing? ***ACTION REQUIRED***: If yes, attach tripeptidyl peptidase 1 (TPP1) enzyme assay or genetic testing results supporting diagnosis.
❒ Yes, *Continue to 6*
❒ No, *Continue to 6*

6. What is the patient's age (in years)?

❒ Less than 3 years old (*If checked, no further questions*)

❒ Greater than or equal to 3 years old (*If checked, go to 7*)

7. Will the requested medication be administered by, or under the direction of a physician knowledgeable in intraventricular administration?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Does the patient have any acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts prior to administration?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the dosage of the requested medication exceed 300 mg once every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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