Brineura® (cerliponase alfa) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Metabolic Specialist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ *Outpatient Infusion Center* Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. OUTPATIENT INFUSION TREATMENT

Requesting Outpatient Infusion Treatment? ☐ Yes ☐ No *If Yes,* ***CPT Code:*** ☐ *S9357* ☐ *96305* ☐ *96366* ☐ *Other* _____

F. PRODUCT INFORMATION

Request is for: Brineura (cerliponase alfa) Dose: _____ **Frequency:** _____

G. DIAGNOSIS INFORMATION – Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

H. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is the patient diagnosed with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) (also known as tripeptidyl peptidase 1 (TPP1) deficiency)?

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

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Was the diagnosis confirmed by either an enzyme assay demonstrating a deficiency of tripeptidyl peptidase 1 (TPP1) enzyme activity OR by genetic testing?

☐ Yes ☐ No Will the requested medication be administered by, or under the direction of a physician knowledgeable in intraventricular administration?

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced no loss of ambulation or a slowed loss of ambulation from baseline?
→ Please indicate ambulation status: ☐ No loss of ambulation ☐ Slowed loss of ambulation

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.