health information designs

Brineura
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving Brineura to meet prior authorization criteria. The prior authorization criteria can be found at **http://hidesigns.com/assets/files/ndmedicaid/2019/Criteria/PA_Criteria.pdf**

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Billing Facility Name	Billing Facility NPI	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**ICD-10 Diagnosis Code(s) for this request:**		

Qualifications for Coverage:

Initial Requests (please answer the questions below):	
Does patient have ventriculoperitoneal shunts?	□ YES □NO
Has the patient's diagnosis been confirmed by a genetic test confirming CLN2 disease?	□ YES □NO
Have results of an enzyme assay confirmed a deficiency of tripeptidyl peptidase 1 (TPP1) in this patient?	□ YES □NO
Have the patient's baseline results of motor and language domains of the Hamburg CLN2 Clinical Rating Scale been attached/faxed in with this request?	□ YES □NO
Renewal Requests (please answer the questions below):	
Does the patient have an acute, unresolved localized infection on or around the device insertion site or suspected or confirmed CNS infection?	□ YES □NO
Have the patient's current results of motor domain of the Hamburg CLN2 Clinical Rating Scale been attached/faxed in with this request?	□ YES □NO
Has the patient responded to therapy compared to pretreatment baseline with stability/lack of decline* in motor function/milestones?	□ YES □NO
**: Decline is defined as having an unreversed (sustained) 2-category decline or an unreversed score of 0 in the Motor domain of the CLN2 Clinical Rating Scale*	

Prescriber (or Staff) / Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*