Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Brineura
(cerliponase alfa)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Brineura ☐ other (Please specify): ICD10:

Dose: Frequency of therapy: Duration of therapy:

Please indicate any CPT codes that will be billed for administration:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ new start
☐ continuation of therapy

Where will this medication be obtained?

☐ Orsini Specialty Pharmacy
☐ Other (please specify):

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

*****This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc). *****
Supportive documentation for all answers must be attached with this request.

Does the patient have a diagnosis of Neuronal Ceroid Lipofuscinosis Type 2 (CLN2)? ☐ Yes ☐ No

(if no) What is the diagnosis related to use?

Has the patient had a genetic test which confirms the diagnosis of CLN2 disease (biallelic pathogenic or likely pathogenic variants in the TPP1 gene)? ☐ Yes ☐ No

Has the patient had a test which confirms reduced activity of tripeptidyl peptidase 1 (TPP1)? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with a metabolic specialist, geneticist, pediatric neurologist, or a physician specializing in the treatment of neuronal ceroid lipofuscinoses (NCLs)? ☐ Yes ☐ No

Is each dose of the requested medication followed by an infusion of intraventricular electrolytes (supplied in the Brineura package)? ☐ Yes ☐ No

Additional pertinent information: *Please include any alternatives tried, with drug name, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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 Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005