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:

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 your patient have a diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2)?
☐ Yes ☐ No, please specify: _____

Is your patient having symptomatic disease? ☐ Yes ☐ No
Does your patient have a deficiency of tripeptidyl peptidase 1 (TPP1) in dry blood spots, leukocytes or fibroblasts? ☐ Yes ☐ No
(if no) Is there documentation that your patient has alterations of BOTH copies (biallelic) of the tripeptidyl peptidase 1 (TPP1) gene? ☐ Yes ☐ No
Is the requested drug being prescribed by, or in consultation with a metabolic specialist, geneticist, pediatric neurologist, or a physician specializing in the treatment of neuronal ceroid lipofuscinosis? ☐ 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.

v033020