

Clinical Policy: Cerliponase Alfa (Brineura)

Reference Number: CP.PHAR.338

Effective Date: 07.01.17

Last Review Date: 08.23

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Cerliponase alfa (Brineura[®]) is a hydrolytic lysosomal N-terminal tripeptidyl peptidase.

FDA Approved Indication(s)

Brineura is indicated to slow the loss of ambulation in symptomatic pediatric patients 3 years of age and older with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation[®] that Brineura is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Late Infantile Neuronal Ceroid Lipofuscinosis Type 2 (must meet all):**

1. Diagnosis of late infantile neuronal CLN2;
2. Prescribed by or in consultation with a neurologist;
3. Age \geq 3 years;
4. Confirmation of CLN2 with both of the following (a and b):
 - a. TPP1 enzyme activity test demonstrating deficient TPP1 enzyme activity in leukocytes;
 - b. Identification of 2 pathogenic mutations *in trans* in the TPP1/CLN2 gene;
5. Motor domain of the CLN2 Clinical Rating Scale score \geq 1 (*see Appendix D*);
6. At the time of request, member does not have acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts;
7. Dose does not exceed 300 mg administered once every other week as an intraventricular infusion.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

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- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy**A. Late Infantile Neuronal Ceroid Lipofuscinosis Type 2 (must meet all):**

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy as evidenced a score of ≥ 1 on the CLN2 Clinical Rating Scale (*see Appendix D*);
3. Member does not have acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts;
4. If request is for a dose increase, new dose does not exceed 300 mg administered once every other week as an intraventricular infusion.

Approval duration: 6 months**B. Other diagnoses/indications (1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

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criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CLN2: ceroid lipofuscinosis type 2
 FDA: Food and Drug Administration
 TPP1: tripeptidyl peptidase 1

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Acute, unresolved localized infection on or around the device insertion site (e.g. cellulitis or abscess); or suspected or confirmed CNS infection (e.g. cloudy CSF or positive CSF gram stain, or meningitis).
 - Acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) .
 - Patients with ventriculoperitoneal shunts.
- Boxed warning(s): none reported

Appendix D: Motor Domain of CLN2 Clinical Rating Scale

- The motor domain of the CLN2 Clinical Rating Scale is scored as follow: walks normally = 3, intermittent falls, clumsiness, obvious instability = 2, no unaided walking or crawling only = 1, immobile, mostly bedridden = 0.
- 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.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
CLN2	300 mg administered once every other week as an intraventricular infusion followed by infusion of intraventricular electrolytes over approximately 4.5 hours	300 mg every other week

VI. Product Availability

Injection: 150 mg/5 mL (30 mg/mL) solution, two single-dose vials per carton co-packaged with Intraventricular Electrolytes Injection 5 mL in a single-dose vial.

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VII. References

1. Brineura Prescribing Information. Novato, CA: BioMarin Pharmaceutical Inc.; March 2020. Available at: <https://www.brineura.com>. Accessed April 25, 2023.
2. Williams RE, Adama HR, Blohm M, et al. Management strategies for CLN2 disease. *Pediatric Neurology*. 2017 Apr;(69):102-112. <http://dx.doi.org/10.1016/j.pediatrneurol.2017.01.034>.
3. Fietz M, AlSayed M, Burke D, et al. Diagnosis of neuronal ceroid lipofuscinosis type 2 (CLN2 disease): Expert recommendations for early detection and laboratory diagnosis. *Molecular Genetics and Metabolism*. 2016 Jul;(119):160-167. doi: 10.1016/j.ymgme.2016.07.011. Epub 2016 Jul 25.
4. Kohlschütter A, Schulz A, Bartsch U, et al. Current and Emerging Treatment Strategies for Neuronal Ceroid Lipofuscinoses. *CNS Drugs* (2019) 33:315-325. <https://doi.org/10.1007/s40263-019-00620-8>.
5. Mole SE, Schulz A, Badoe E, et al. Guidelines on the diagnosis, clinical assessments, treatment, and management of CLN2 disease patients. *Orphanet Journal of Rare Diseases*. 2021 April 21; 16(1):185.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0567	Injection, cerliponase alfa, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: added Commercial line of business; no significant changes; references reviewed and updated.	06.15.18	08.18
3Q 2019 annual review: no significant changes; added new contraindications; references reviewed and updated	05.19.19	08.19
3Q 2020 annual review: no significant changes; references reviewed and updated.	04.20.20	08.20
3Q 2021 annual review: no significant changes; added HCPCS code; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	05.04.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.02.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.21.22	
3Q 2023 annual review: revised and added to continuation of therapy to ensure member does not have acute intraventricular access device-	04.14.23	08.23

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts; references reviewed and updated.		

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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