Clinical Policy: Cerliponase Alfa (Brineura)

Reference Number: LA.PHAR.338
Effective Date: 10.24.23
Last Review Date: 07.18.26
Line of Business: Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

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 pediatric patients with neuronal ceroid lipofuscinosis type 2 (CLN2 disease), 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 Louisiana Healthcare Connections that Brineura is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Neuronal Ceroid Lipofuscinosis Type 2 (must meet all)**:**

1. Diagnosis of neuronal CLN2;
2. Prescribed by or in consultation with a neurologist;
3. Member weighs ≥ 2.5 kg;
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 ≥ 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: 12 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 LA.PMN.255.

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 LA.PMN.53.

II. Continued Therapy

A. Neuronal Ceroid Lipofuscinosis Type 2 (must meet all)**:**

a. 1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;

2. 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: 12 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 LA.PMN.255.
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 LA.PMN.53.

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 LA.PMN.53.

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): hypersensitivity reactions including anaphylaxis

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	Brineura is administered once every other week as an intraventricular infusion with the following age-based dosages: • Birth to < 6 months: 100 mg • 6 months to < 1 year: 150 mg • 1 year to < 2 years: 200 mg (first 4 doses) followed by 300 mg (subsequent doses) • 2 years and older: 300 mg	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.

VII. References

1. Brineura Prescribing Information. Novato, CA: BioMarin Pharmaceutical Inc.; July 2024. Available at: https://www.brineura.com. Accessed April 22, 2026.
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	LDH Approval Date
Converted corporate to local policy.3Q 2023 annual review: revised and added to continuation of therapy to ensure member does not have acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts; references reviewed and updated.	06.20.23	10.24.23
Revised and added to continuation of therapy to ensure member does not have acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection) or ventriculoperitoneal shunts; references reviewed and updated.	05.27.24	08.20.24
Updated criteria to reflect the newly FDA-approved indication expansion to include symptomatic and presymptomatic patients younger than 3 years of age, including the following changes: removed any references to "late infantile" disease, replaced the age requirement with the 2.5 kg minimum weight requirement per dosing recommendations in the Prescribing Information; added the Boxed Warning re: hypersensitivity reactions including anaphylaxis; references reviewed and updated.	10.03.24	01.27.25
Annual review: no significant changes; references reviewed and updated.	08.18.25	N/A, no material changes
Annual review: updated Initial Approval and Continued Therapy authorization durations from 6 months to 12 months; references reviewed and updated.	07.18.26	10.07.26

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. LHCC 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.

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

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