

Clinical Policy: Cerliponasa Alfa (Brineura)

Reference Number: CP.PHAR.338

Effective Date: 07.01.17

Last Review Date: 08.18

Line of Business: Commercial, Medicaid, HIM-Medical Benefit

[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;
6. At the time of request, member does not have 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

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

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

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1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced a score of ≥ 1 on the CLN2 Clinical Rating Scale;
3. 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. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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.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

- Acute intraventricular access device-related complications (e.g., leakage, device failure, or device-related infection)
- Patients with ventriculoperitoneal shunts

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.

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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

VII. References

1. Brineura Prescribing Information. Novato, CA: BioMarin Pharmaceutical Inc.; April 2017. Available at: <https://www.brineura.com>. Accessed June 15, 2018.
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.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05.17	07.17
2Q 2018 annual review: added HIM lines of business; age added; modified continued therapy criteria to allow provider to determine presence of positive response instead of requiring no decline or decline or one category of CLN2 Clinical Rating Scale score and added requirement that member has at least a score of at least 1 to ensure continued ambulation; references reviewed and updated.	02.19.18	05.18
3Q 2018 annual review: added Commercial line of business; no significant changes; references reviewed and updated.	06.15.18	08.18

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

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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.

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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