Drug Therapy Guidelines	Applicable*	Brineura® (cerliponase alfa)
Medical Benefit	x	**Effective:** 11/1/18
Pharmacy- Formulary 1		**Next Review:** 9/19
Pharmacy- Formulary 2		**Date of Origin**: 8/17
Pharmacy- Formulary 3/Exclusive		**Review Dates:** 6/17, 9/17, 9/18
Pharmacy- Formulary 4/AON		

I. Medication Description

Cerliponase alfa is an enzyme replacement therapy for the management of patients with late infantile neuronal ceroid lipofuscinosis type 2 (CLN2), a form of Batten disease. CLN2 is a rare, genetic, fatal neurodegenerative disease caused by a deficiency of the lysosomal enzyme tripeptidyl peptidase-1 (TPP1). Cerliponase alfa is a recombinant form of TPP1 that is administered into the cerebrospinal fluid (CSF) by intraventricular infusion using a specific surgically implanted intraventricular access device. It is taken up by target cells in the CNS and is translocated to the lysomomes through the Cation Independent Mannose-6-Phospate Receptor (CI-MPR, also known as M6P/IGF2 receptor). Cerliponase alfa is activated in the lysosome and the activated proteolytic form of rhTPP1 cleaves tripeptides from the N-terminus of proteins.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Brineura is available when the following criteria have been met:

- Medication is prescribed by or in consultation with a metabolic specialist, geneticist, pediatric neurologist, or a physician specializing in the treatment of neuronal ceroid lipofuscinoses (NCLs) **AND**
- Member is 3 to 17 years of age **AND**
- Member has a diagnosis of late-infantile neuronal ceroid lipofuscinosis type 2 (CLN2) disease as confirmed by ONE of the following :
  - Genetic test confirming the diagnosis of CLN2 disease **OR**
  - Enzyme assay demonstrating deficiency of tripeptidyl peptidase 1 (TPP1) enzyme activity **AND**
- Member is symptomatic and treatment is being given to slow the loss of ambulation **AND**
- Medication will be administered to the cerebrospinal fluid (CSF) by infusion via a surgically implanted reservoir and catheter by, or under the direction of a physician knowledgeable in intraventricular administration.

IV. Quantity Limitations

Quantity is limited to 2 boxes (each box containing 2 Brineura 150 mg/5 ml vials and 1 vial of Intraventricular Electrolytes Injection) per month to accommodate one dose (300mg) administered every other week as an intraventricular infusion.

V. Coverage Duration

Coverage is available for 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:

- Stabilization of disease or in absence of disease progression (i.e. lack of decline of motor function) **AND**
- Member remains ambulatory **AND**
- Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

- Available as 150mg/5mL solution for Injection (2 vials of Brineura 150 mg/5 mL supplied with 1 vial, 5ml Intraventricular Electrolytes Injection in each package)
- J3590: 150 mg/5 mL
- Pertinent Indication:
  - Neuronal ceroid lipofuscinosis: E75.4

VIII. Summary of Policy Changes

- 8/8/2017: new policy
- 10/11/17: no policy changes
- 11/1/18: updated renewal criteria to require continued ability to ambulate

IX. References

1. Clinical Pharmacology. www.clinicalpharmacology.com. Gold Standard. Copyright 2017. Accessed 6/2018.
2. Brineura® (cerliponase alfa). [Prescribing Information]. BioMarin Pharmaceutical Inc. Novato, CA. April 2017.
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. Mol Genet Metab. 2016;119(1-2):160-167.
4. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual: Chapter 15. (CMS Publication No. 100-02). Retrieved from http://www.cms.hhs.gov.

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

**These guidelines are not applicable to benefits covered under Medicare Advantage. Medicare Advantage benefit coverage requests are reviewed in accordance with the guidance set forth in Chapter 15 Section 50 of the Centers for Medicare & Medicaid Services Medicare Benefit Policy Manual*

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.