Pharmacy Policy Bulletin: J-0400 Myalept (metreleptin) – Commercial and Healthcare Reform	
Number: J-0400	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1.)**: **1.** Miscellaneous Specialty Drugs Injectable = Yes w/ Prior Authorization **Healthcare Reform:** Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-0400-015	**Original Date:** 06/04/2014
Effective Date: 02/14/2025	**Review Date:** 01/29/2025

Drugs Product(s):	• Myalept (metreleptin)
FDA-Approved Indication(s):	• Adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy

Background:	• Myalept (metreleptin) is a recombinant human leptin analog which binds and activates the human leptin receptor. Leptin levels are related to the amount of fat in the body. Members with lipodystrophy have a leptin deficiency, which results in hypertriglyceridemia, insulin resistance, and fat deposition around the liver and muscle (non-adipose tissues). • Myalept was studied in an open-label, single-arm study in patients with congenital or acquired lipodystrophy and diabetes mellitus, hypertriglyceridemia, and/or increased fasting insulin. The results showed a mean percent change from baseline at month 12 of -2.4% for $HbA1_c$ and -49% for fasting glucose. The median percent change from baseline for fasting triglycerides was -55%. • Common hyperglycemia symptoms include polyuria, polydipsia, polyphagia and unexplained weight loss. • Prescribing Considerations: ○ Myalept is only available through the Myalept Risk Evaluation and Mitigation Strategies program (REMS) program because of the risks associated with the development of anti-metreleptin antibodies that neutralize endogenous leptin and/or Myalept ,and the risk for lymphoma. ○ Myalept is not indicated for the treatment of complications of partial lipodystrophy. ○ Myalept is not indicated for members with HIV-related lipodystrophy. ○ Myalept is not indicated for metabolic disorders including hypertriglyceridemia and obesity, diabetes patients without concurrent evidence of congenital or acquired generalized lipodystrophy, or non-alcoholic steatohepatitis (NASH).

Approval Criteria

I. Initial Approval

When a benefit, coverage of Myalept may be approved when all of the following criteria are met **(A. through D.)**:

- **A.** The member has a diagnosis of congenital generalized lipodystrophy (specifically, Berardinelli-Seip syndrome) or acquired generalized lipodystrophy (specifically, Lawrence syndrome) (ICD-10: E88.1).
- **B.** The member meets one (1) of the following criteria **(1. or 2.)**:
  - **1.** The member is a male and has a leptin level of < 8 ng/mL.
  - **2.** The member is a female and has a leptin level of < 12 ng/mL.
- **C.** The member meets one (1) of the following criteria **(1. through 3.)**:
  - **1.** The member has a diagnosis of diabetes mellitus (ICD-10: E08 - E13) defined as one (1) of the following **(a. through d.)**:
    - **a.** HbA1c ≥ 6.5%
    - **b.** Fasting blood glucose ≥ 126 mg/dL
    - **c.** Two-hour plasma glucose ≥ 200 mg/dL
    - **d.** Symptoms of hyperglycemia with random plasma glucose ≥ 200 mg/dL
  - **2.** Fasting insulin level > 30 µU/mL
  - **3.** Fasting hypertriglyceridemia > 200 mg/dL
- **D.** The member has experienced therapeutic failure to one (1) previous therapy for diabetes (for example, metformin, insulin) or hypertriglyceridemia (for example, statin, fibrate).

II. Reauthorization

When a benefit, reauthorization of Myalept may be approved when one (1) of the following criteria is met **(A., B., or C.)**:

- **A.** Decreased HbA1c by at least 0.8% from baseline.
- **B.** Decreased fasting triglycerides by at least 25% from baseline.
- **C.** Decreased fasting plasma glucose by at least 25% from baseline.

III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

Limitations of Coverage

I. Coverage of drugs addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.

II. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

Automatic Approval Criteria

None

References:

1. Myalept [package insert]. Princeton, NJ: Amylin Pharmaceuticals, LLC.; February 2022.
2. Chan, Jean L., et al. Clinical effects of long-term metreleptin treatment in patients with

lipodystrophy. Endocrine Practice 17.6 (2011): 922-932.
3. Astrazeneca News Release. US FDA approves orphan drug Myalept™ (metreleptin for injection). Available at: https://www.astrazeneca-us.com/media/press-releases/2014/us-fda-approves-orphan-drug-myalept-20140225.html#modal-historic-confirmation. Accessed December 16, 2019.
4. Handelsman, Yehuda, et al. The Clinical Approach to the Detection of Lipodystrophy– An AACE Consensus Statement. Endocrine Practice 19.1 (2013): 107-116.
5. Brown RJ, Araujo-Vilar D, Cheung PT, et al. The diagnosis and management of lipodystrophy syndromes: a multi-society practice guideline. *J Clin Endocrinol Metab*. 2016;101(12):4500-4511.

American Diabetes Association Professional Practice Committee. 2. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes-2025. *Diabetes Care*. 2025 Jan 1;48(Supplement_1):S27-S49.