Clinical Policy: Metreleptin (Myalept)

Reference Number: LA.PHAR.425
Effective Date: 05.03.24
Last Review Date: 11.19.24
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

Metreleptin (Myalept®) is a recombinant human leptin analog.

FDA Approved Indication(s)

Myalept is indicated as an adjunct to diet as replacement therapy to treat the complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy.

Limitation(s) of use:

- The safety and effectiveness of Myalept for the treatment of complications of partial lipodystrophy have not been established.
- The safety and effectiveness of Myalept for the treatment of liver disease, including nonalcoholic steatohepatitis (NASH), have not been established.
- Myalept is not indicated for use in patients with HIV-related lipodystrophy.
- Myalept is not indicated for use in patients with metabolic disease, without concurrent evidence of generalized lipodystrophy.

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 Myalept is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Leptin Deficiency (must meet all)**:**

1. Diagnosis of leptin deficiency as evidenced by baseline leptin level < 12 ng/mL;
2. Prescribed by or in consultation with an endocrinologist or geneticist;
3. Age ≥ 1 year;
4. Member has one of the following (a or b):
   a. Congenital generalized lipodystrophy (Berardinelli-Seip syndrome) as evidenced by presence of at least one gene mutation (i.e., AGPAT2, BSCL2, CAV1, PTF);
   b. Acquired generalized lipodystrophy (Lawrence syndrome);
5. Dose does not exceed (a or b):
   a. Body weight ≤ 40 kg: 0.13 mg/kg per day;
   b. Body weight > 40 kg: 10 mg per day.

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 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 the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Leptin Deficiency (must meet all)**:**
- a. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;

1. Member is responding positively to therapy;
2. If request is for a dose increase, new dose does not exceed (a or b):
   - a. Body weight ≤ 40 kg: 0.13 mg/kg per day;
   - b. Body weight > 40 kg: 10 mg per day.

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 the relevant line of business: LA.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 policies – LA.PMN.53 for Medicaid, or evidence of coverage documents;
B. General obesity not associated with congenital leptin deficiency;
C. HIV-related lipodystrophy;
D. Liver disease, including NASH.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HIV: human immunodeficiency virus
NASH: nonalcoholic steatohepatitis

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - General obesity not associated with congenital leptin deficiency: Myalept has not been shown to be effective in treating general obesity, and the development of anti-metreleptin antibodies with neutralizing activity has been reported in obese patients treated with Myalept
  - Hypersensitivity to metreleptin
- Boxed warning(s): risk of anti-metreleptin antibodies with neutralizing activity and risk of lymphoma
  - Because of these risks, Myalept is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Myalept REMS Program

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Complications of leptin deficiency in patients with congenital or acquired generalized lipodystrophy	Weight ≤ 40 kg: 0.06 to 0.13 mg/kg SC QD (adjust in increments of 0.02 mg/kg) Weight > 40 kg: Males: 2.5 to 10 mg SC QD (adjust in increments of 1.25 to 2.5 mg/day) Females: 5 to 10 mg SC QD (adjust in increments of 1.25 to 2.5 mg/day)	Weight ≤ 40 kg: 0.13 mg/kg/day Weight > 40 kg: 10 mg/day

VI. Product Availability

Lyophilized cake in vial to be reconstituted: 11.3 mg/vial (5 mg/mL after reconstitution)

VII. References

1. Myalept Prescribing Information. Dublin, Ireland: Amryt Pharmaceuticals, Inc; February 2022. Available at http://www.myalept.com. Accessed on May 23, 2024.
2. 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. doi: 10.1210/jc.2016-2466.
3. National Organization for Rare Disorders. Congenital generalized lipodystrophy. Available at: https://rarediseases.org/rare-diseases/congenital-generalized-lipodystrophy. Last updated December 15, 2022. Accessed May 23, 2024.
4. Leptin to treat lipodystrophy (NCT00025883). ClinicalTrials.gov. Available at: https://clinicaltrials.gov/ct2/show/NCT00025883. Accessed May 23, 2024.

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
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.09.23	08.28.23
Reviewed and updated references	02.21.24	05.03.24
No significant changes; references reviewed and updated.	11.19.24	

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 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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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.

CLINICAL POLICY
Metreleptin

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 LHCC has no control or right of control. Providers are not agents or employees of LHCC.