Clinical Policy: Metreleptin (Myalept)
Reference Number: CP.PCH.05
Effective Date: 11.16.16
Last Review Date: 08.18
Line of Business: Commercial, HIM

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

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 health plans affiliated with Centene Corporation® 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;
      2. Age ≥ 1 year;
      3. Member has congenital or acquired generalized lipodystrophy;
      4. Dose does not exceed (a or b):
         a. Body weight ≤ 40 kg: 0.13 mg/kg/day;
         b. Body weight > 40 kg: 10 mg/day.

   Approval duration:
   HIM – 6 months
   Commercial – 6 months or to the member’s renewal date, whichever is longer

   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.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

II. Continued Therapy
   A. Leptin Deficiency (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, new dose does not exceed (a or b):
         a. Body weight ≤ 40 kg: 0.13 mg/kg/day;
         b. Body weight > 40 kg: 10 mg/day.
   
   Approval duration:
   HIM – 12 months
   Commercial – 6 months or to the member’s renewal date, whichever is longer

   B. Other diagnoses/indications (must meet 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.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

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 – CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace 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
• 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.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
</table>
| 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

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Converted to new template. Minor changes to verbiage and grammar. References updated.</td>
<td>1.17.17</td>
<td>11.17</td>
</tr>
<tr>
<td>3Q 2018 annual review: policies combined for Centene HIM (new) and Commercial lines of business; no significant changes; age added; approval durations for Commercial modified from length of benefit to 6/6 months; added HIV-related lipodystrophy and liver disease as indications not covered per PI; references reviewed and updated.</td>
<td>04.02.18</td>
<td>08.18</td>
</tr>
</tbody>
</table>

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
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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

©2018 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise