Pharmacy Drug Policy Checklist

POLICY NAME	Myalept (metreleptin)	POLICY #	2301P

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **2.1** All other indications
- ☐ **2.2** Not indicated for use in patients with HIV-related lipodystrophy
- ☐ **2.3** Not indicated for use in patients with metabolic disease, without concurrent evidence of generalized lipodystrophy

Coverage Criteria for the Treatment of Leptin Deficiency, in Addition to Diet, in Patients with Congenital or Acquired Generalized Lipodystrophy

- ☐ **1.1** Diagnosis of congenital or acquired generalized lipodystrophy (abnormal fat tissue distribution) caused by leptin deficiency
- ☐ **1.2** Ordered by a specialist enrolled in the Myalept Risk Evaluation and Mitigation Strategy (REMS) Program

1 Initial: 12 months

- ☐ **3.2** Reauthorization: 12 months with documented benefit from therapy CPT Codes HCPCS Codes