Pharmacy Drug Policy Checklist

POLICY NAME	Myalept (metreleptin)	POLICY #	2301P

Criteria

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

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

1 Initial: 12 months

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