Updated: 05/2021
DMMA Approved: 05/2021

Request for Prior Authorization for Evkeeza (evinacumab-dgnb)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Evkeeza (evinacumab-dgnb)require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Evkeeza (evinacumab-dgnb) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of **treatment of homozygous familial hypercholesterolemia (HoFH)** and the following criteria is met:

- Member must be 12 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- The medication is being prescribed by or in consultation with a qualified specialist (cardiologist, endocrinologist, lipid specialist)
- Documented diagnosis of HoFH (clinical documentation and laboratory results must be provided to support the diagnosis) confirmed by:
    - An untreated LDL-C >500 mg/dL or a treated LDL-C ≥ 300 mg/dL with one of the following:
        - Presence of cutaneous or tendon xanthoma before 10 years of age
        - Both parents have documented elevated LDL-C before lipid-lowering treatment (pre-treatment) consistent with a diagnosis of heterozygous familial hypercholesterolemia [e.g. untreated LDL-C >190 mg/dL]
    - Previous history of genetic confirmation of two mutant alleles in the LDLR, Apo-B, PCSK9, or LDLRAP1 gene locus
- Documentation of lipid panel results at baseline (pre-treatment), current LDL level with treatment for at least one month, and goal LDL level are provided.
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to all of the following:
    - a statin in combination with ezetimibe
    - a PCSK9 inhibitor (requires a prior authorization)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - LDL-C drawn after treatment initiation demonstrating improvement while on therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or

peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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EVKEEZA (EVINACUMAB-DGNB) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

☐ **Homozygous Familial hypercholesterolemia (HoFH)**

Has the diagnosis been confirmed by any of the following (check all that apply)? ☐ Yes ☐ No

- ☐ Untreated LDL-C levels consistent with heterozygous FH in both parents [untreated LDL-C >190mg/dL]
- ☐ Presence of cutaneous or tendon xanthoma before 10 years of age
- ☐ Previous genetic confirmation of two mutant alleles in the LDLR, Apo-B, PCKS9 or LDLRAP1 gene locus

Baseline LDL-C: _____ Date:_____
Current LDL-C: _____ Date:_____
Goal LDL-C: _____
% Reduction in LDL-C required to reach goal: _____ Date: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

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Current LDL-C on Evkeeza (evinacumab-dgnb): _____ Date lab drawn:_____	
SUPPORTING INFORMATION or CLINICAL RATIONALE	
Prescribing Provider Signature	Date