HIGHMARK HEALTH OPTIONS

Updated: 04/2025
Approved: 04/2025

Request for Prior Authorization for Evkeeza (evinacumab-dgnb)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

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:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines.
- The prescribed medication is age appropriate based upon FDA-approved labeling.
- 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 one of the following:
    - 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:
    - at least two statins at the maximally tolerated dose for at least 3 months.
    - a statin in combination with ezetimibe for at least 8 weeks
    - a PCSK9 inhibitor for at least 3 months
- The member will be taking the requested medication concurrently with a maximally tolerated statin (if statin tolerant)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation the member is adherent to statin treatment in combination with the requested therapy (if statin tolerant)
    - LDL-C drawn after treatment initiation demonstrates 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication 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: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 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:	
Member 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:** _____

Will the member be taking the medication concurrently with a statin ? ☐ Yes ☐ No
If no please provide documentation of why the member cannot take a statin

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:
Current LDL-C on Evkeeza (evinacumab-dgnb): _____ **Date lab drawn:** _____

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EVKEEZA (EVINACUMAB-DGNB) PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2		
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MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:
SUPPORTING INFORMATION or CLINICAL RATIONALE		
Prescribing Provider Signature	Date	