BlueCross BlueShield Nebraska

X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

POLICY

Target Agent

Evkeeza (evinacumab)

Objective: The intent of the evinacumab prior authorization is to encourage appropriate use according to clinical trial data and FDA approved labeling.

Prior Authorization Criteria for Approval

1. The target agent will be considered medically necessary when the following are met:
    a. Documentation is provided that individual has Homozygous Familial Hypercholesterolemia (HoFH) confirmed by:
        i. Presence of two mutant alleles at the LDLR, apoB, PCSK9, or ARH adaptor protein (LDLRAP1) gene locus; **OR**
        ii. Presence of the following:
            1. An untreated LDL-C concentration greater than 500mg/dL (13mmol/L); **OR**
            2. Treated LDL-C greater than or equal to 300mg/dL (7.76mmol/L) **AND one** of the following
                a. Cutaneous or tendonous xanthoma before age 10 years; **OR**
                b. Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (greater than 190mg/dL);**AND**
2. Individual meets one of the following:
    a. Individual is on high intensity statin therapy or statin therapy at the maximum tolerated dose (high intensity statin is defined as

BlueCross BlueShield Nebraska

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X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

ii. Statin associated rhabdomyolysis after a trial of one statin; **OR**

c. Individual has a contraindication for statin therapy including active liver disease, unexplained persistent elevation of hepatic transaminases or pregnancy; **AND**

3. Individual has had a trial and inadequate response or intolerance to ezetimibe; **AND**
4. Documentation is provided that individual has had a trial and inadequate response or intolerance to proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor therapy; **OR**
5. Documentation is provided that genetic testing has confirmed the individual is LDLR negative; **AND**
6. The agent is being prescribed by, or in consultation with, a cardiologist, an endocrinologist, and/or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

Initial length of approval: 6 months

Renewal criteria:

1. Individual continues to receive concomitant lipid lowering therapy including maximally tolerated statin therapy, ezetimibe and/or PCSK9 inhibitor therapy; **AND**
2. Documentation of LDL-C reduction has been provided.

Duration of approval: 12 months.

Dates

Original Effective
05-05-2021
Last Review
11-06-2024
Next Review
11-10-2025

DESCRIPTION

Evkeeza (evinacumab), an angiopoietin-like 3 (ANGPTL3) inhibitor monoclonal antibody is approved by the Food and Drug Administration (FDA) as an adjunct to other low-density lipoprotein-cholesterol lowering therapies for the treatment of individuals aged 12 years and older with homozygous familial hypercholesterolemia. The safety and effectiveness of Evkeeza have not been established in

BlueCross BlueShield Nebraska

X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

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There are two types of familial hypercholesterolemia (FH). Heterozygous FH (HeFH) is the more common type occurring in approximately 1 in 200 to 250 individuals. Individuals with HeFH have one altered copy of a cholesterol-regulating gene. Homozygous FH (HoFH) is the rare, more severe form, occurring in approximately 1 in 300,000 to 400,000 individuals. Individuals with HoFH have two altered copies of cholesterol-regulating genes. HoFH can cause LDL-C levels more than six times as high as normal (for example, 650-1,000 mg/dL).

Definitive diagnosis of familial hypercholesterolemia is established by genetic confirmation of a mutation in one of the genes critical for low density lipoprotein cholesterol (LDL-C) catabolism. If genetic testing is unavailable, diagnosis can be established though clinical criteria based on LDL-C levels, clinical presentation, and family history.

In the clinical setting, statins are considered first-line drug therapy, in addition to healthy lifestyle interventions, in individuals requiring treatment for abnormal cholesterol. Other lipid lowering therapies should be considered second-line options for individuals needing additional cholesterol lowering or who can’t tolerate moderate to high doses of statins.

In 2018, the American Heart Association (AHA)/American College of Cardiology (ACC) released guidelines on the management of blood cholesterol. In very high-risk ASCVD, the guidance recommends to consider adding non-statins to statin therapy when LDL-C remains greater than or equal to 70 mg/dL. Ezetimibe is the first agent to consider adding on to maximally tolerated statin therapy. PCSK9 inhibitors can be considered for addition if LDL-C remains greater than or equal to 70 mg/dL on statin therapy combined with ezetimibe.

In 2017, the American Association of Clinical Endocrinologists and American College of Endocrinology (AACE/ACE) published guidelines for management of dyslipidemia and prevention of cardiovascular disease. In terms of treatment goals, AACE/ACE suggests very high-risk individuals with established coronary, carotid, and peripheral vascular disease or diabetes who also have at least one additional risk factor should be treated with statins to target a reduced LDL-C treatment goal of less than 70 mg/dL. Extreme risk individuals should be treated with statins to target an even lower LDL-C goal of less than 55 mg/dL.

BlueCross BlueShield Nebraska

X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

FH. The guidance also states that Juxtapid may be useful for individuals with HoFH unresponsive to PCSK9 inhibitor therapy.

In 2017, the National Lipid Association (NLA) published recommendations from an expert panel on the use of PCSK9 inhibitors in adults. The panel recommended PCSK9 inhibitor therapy may be considered to further reduce LDL-C in individuals with HoFH, either of unknown genotype or those known to be LDLR defective, on maximally-tolerated statin therapy with or without ezetimibe with a LDL-C greater than or equal to 70 mg/dL or non-HDL-C greater than or equal to 100 mg/dL. The panel indicated PCSK9 therapy appears to be ineffective in individuals with HoFH who are LDLR negative.

Statins have labeled warnings for liver enzyme abnormalities and skeletal muscle effects including myopathy and rhabdomyolysis. Statin-induced adverse events leading to intolerance are possible, but it is estimated 74% of individuals considered statin intolerant can successfully be treated with a statin long-term (based on observational data). Definitions of statin intolerance are variable but the National Lipid Association has provided guidance defining statin intolerance as a clinical syndrome characterized by the inability to tolerate at least two statins, one statin at the lowest starting daily dose and another statin at any daily dose, due to either objectionable symptoms or abnormal lab determinations, which are temporally related to statin treatment and reversible upon statin discontinuation, but reproducible by re-challenge with other known determinants being excluded (including hypothyroidism, interacting drugs, concurrent illnesses, significant changes in physical activity or exercise and underlying muscle disease).

Safety

Contraindications to evinacumab-dgnb include[2]:

- Patients with history of serious hypersensitivity reaction to evinacumab-dgnb or to any of the excipients in Evkeeza.

Evinacumab-dgnb contains the following Black Box Warnings[2]:

- None

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X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

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X.168 EVKEEZA (EVINACUMAB) (REQUIRES PRIOR AUTHORIZATION)

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REVISIONS

12-05-2023
Policy reviewed at Medical Policy Committee meeting on 11/8/2023 – no changes to policy

06-25-2021
Added new code for 07/01/2021: C9079