Pharmacy Drug Policy Checklist

POLICY NAME	Evkeeza (evinacumab)	POLICY #	2837P

Criteria

Coverage Criteria for Homozygous Familial Hypercholesterolemia (HoFH)

- ☐ **1.1** Documented diagnosis of Homozygous Familial Hypercholesterolemia, confirmed by gene mutations or a supported clinical diagnostic tool
  - Defined as hyperlipidemia due to a genetic or inherited condition that causes high levels of LDL, or “bad” cholesterol
- ☐ **1.2** Documentation of ACC/AHA 10-year risk calculation of 7.5% or greater
- ☐ **1.3** LDL cholesterol level greater than 100mg/dL within the last 30 days
- ☐ **1.4** Age 5 years or older
- ☐ **1.5** Ordered by or in consultation with a cardiologist (doctor of the heart and blood vessels), endocrinologist (hormone doctor), or lipid specialist, to be used in combination with a low-fat diet and exercise
- ☐ **1.6** Member is currently taking a statin drug at the highest tolerated dose, plus ezetimibe, plus a PCSK9 inhibitor (Praluent or Repatha) for at least 90 days, but has not had adequate lipid-lowering response
  - Defined as an inability to decrease LDL level by 50% with claims history showing that member has filled at least 150 days of all medications in the last 6 months, OR
  - Defined as an ability to decrease the LDL level by 50% or more, but the member still does not reach the target LDL goal with claims history showing that member has filled at least 150 days of all medications in the last 6 months
- ☐ **1.7** Documented intolerance to statin therapy (defined as severe myalgias/muscle aches and/or creatine kinase levels greater than 10 times the upper limit of the lab reference range)
- ☐ **1.8** Request for coverage is reviewed by both a pharmacist and medical director

FDA-Approved Dosing

- ☐ **2.1** Dose: 15 mg/kg every 4 weeks