

POLICY NAME	Evkeeza (evinacumab)	POLICY #	2837P
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Criteria

Coverage Criteria for Homozygous Familial Hypercholesterolemia (HoFH)

- ☐ 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
- ☐ Documentation of ACC/AHA 10-year risk calculation of 7.5% or greater
- ☐ LDL cholesterol level greater than 100mg/dL within the last 30 days
- ☐ Age 5 years or older
- ☐ 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
- ☐ 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
- ☐ 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)
- ☐ Request for coverage is reviewed by both a pharmacist and medical director

FDA-Approved Dosing

- ☐ Dose: 15 mg/kg every 4 weeks