Evkeeza™ (evinacumab-dgnb)
(Intravenous)

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I. Length of Authorization

Coverage is provided for 3 months for initial approval and may be renewed every 12 months.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Evkeeza 345 mg/2.3 mL single-dose vial: 2 vials per 28 days
- Evkeeza 1200 mg/8 mL single-dose vial: 1 vial per 28 days

B. Max Units (per dose and over time) [HCPCS Unit]:

- 378 billable units (1890 mg) every 28 days

III. Initial Approval Criteria [1]

Coverage is provided in the following conditions:

- Patient is at least 5 years of age; **AND**
- Baseline low-density lipoprotein cholesterol (LDL-C) labs must be obtained prior to initiating treatment (required for renewal); **AND**
- Patient does not have a diagnosis of heterozygous familial hypercholesterolemia (HeFH); **AND**

Universal Criteria

- Must be prescribed by, or in consultation with, a specialist in cardiology, lipidology, or endocrinology; **AND**
- Will not be used in combination with lomitapide; **AND**

Homozygous Familial Hypercholesterolemia (HoFH) † Φ [1,3,5,6,11,12]

- Patient has a confirmed diagnosis of Homozygous Familial Hypercholesterolemia (HoFH) by any of the following:
    - Confirmed DNA test for functional mutation(s) in LDL receptor alleles or alleles known to affect LDL receptor functionality; **OR**
    - Untreated LDL-C > 500 mg/dL or treated LDL-C ≥ 300 mg/dL; **AND**
        - Cutaneous or tendon xanthoma before age 10 years; **OR**

    - Untreated LDL-C levels in both parents consistent with HeFH; **AND**
- Must be used as an adjunct to a low-fat or heart-healthy diet; **AND**
- Patient has been receiving stable background lipid lowering therapy for at least 4 weeks; **AND**
- Therapy will be used in conjunction with other LDL-lowering therapies (e.g., statins, ezetimibe, PCSK9 inhibitors, LDL apheresis); **AND**
- Patient has tried and failed at least a 3 month trial of adherent therapy with: ezetimibe used in combination with the highest available (or maximally tolerated*****) dose of atorvastatin OR rosuvastatin, unless contraindicated; **AND**
- Patient has tried and failed at least a 3 month trial of adherent therapy with: combination therapy consisting of the highest available (or maximally tolerated*****) dose of atorvastatin OR rosuvastatin, ezetimibe, AND a PSCK9 inhibitor indicated for HoFH (e.g., evolocumab), unless contraindicated; **AND**
- Despite pharmacological treatment, unless contraindicated, with a PCSK9 inhibitor, statin, and ezetimibe, the patient's LDL cholesterol ≥ 100 mg/dL (or ≥ 70 mg/dL for patients with clinical atherosclerotic cardiovascular disease [ASCVD])

† FDA Approved Indication(s); ‡ Compendia recommended indication(s); Φ Orphan Drug

*****If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, a causal relationship must be established between statin use and muscle symptoms.

- Patient has evidence of pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
    - Muscle symptoms resolve after discontinuation of statin; **AND**
    - Muscle symptoms occurred when re-challenged at a lower dose of the same statin; **AND**
    - Muscle symptoms occurred after switching to an alternative statin; **AND**
    - Non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease) have been ruled out; **OR**
- The patient has been diagnosed with rhabdomyolysis associated with statin use
    - The diagnosis should be supported by acute neuromuscular illness or dark urine **AND** an acute elevation in creatine kinase (usually > 5,000 IU/L or 5 times the upper limit of normal [ULN])

IV. Renewal Criteria [1,8]

Coverage can be renewed based upon the following criteria:

- Patient continues to meet universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from therapy. Examples of unacceptable toxicity include: severe hypersensitivity reactions, etc.; **AND**
- Patient has had a reduction in LDL-C, when compared to the baseline labs (prior to initiating evinacumab); **AND**

- Patient continues to adhere to diet and background lipid lowering therapy (e.g., statin, ezetimibe, PCSK9-I, lomitapide, LDL apheresis)

V. Dosage/Administration [1]

Indication	Dose
Homozygous Familial Hypercholesterolemia (HoFH)	Administer 15 mg/kg as an intravenous (IV) infusion once monthly (every 4 weeks). • If a dose is missed, administer as soon as possible. Thereafter, Evkeeza should be scheduled monthly from the date of the last dose. • Assess LDL-C when clinically appropriate. The LDL-lowering effect of may be measured as early as 2 weeks after initiation.

VI. Billing Code/Availability Information

HCPCS code:

- J1305 – Injection, evinacumab-dgnb, 5 mg; 1 billable unit = 5 mg

NDC:

- Evkeeza 345 mg/2.3 mL (150 mg/mL) single-dose vial: 61755-0013-xx
- Evkeeza 1,200 mg/8 mL (150 mg/mL) single-dose vial: 61755-0010-xx

VII. References

1. Evkeeza [package insert]. Tarrytown, NY; Regeneron, Inc.; March 2023. Accessed March 2023.
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2014. Available at: http://www.sciencedirect.com/science/article/pii/S1933287414002748. Accessed July 29, 2015.

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7. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways. J Am Coll Cardiol. 2017 Oct 3;70(14):1785-1822.
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11. Cuchel M, Bruckert E, Ginsberg HN, et al. Homozygous familial hypercholesterolaemia: new insights and guidance for clinicians to improve detection and clinical management. A position paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. Eur Heart J. 2014 Aug 21;35(32):2146-57. doi: 10.1093/eurheartj/ehu274. Epub 2014 Jul 22
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Appendix 1 – Covered Diagnosis Codes

ICD-10	ICD-10 Description
E78.00	Pure Hypercholesterolemia, unspecified

E78.01	Familial hypercholesterolemia

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Articles may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC