Evkeeza™ (evinacumab-dgnb)
(Intravenous)

I. Length of Authorization

Coverage is provided for three 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]:
   • 1890 mg every 28 days

III. Initial Approval Criteria

Coverage is provided in the following conditions:

• Patient age 12 years or older: AND
• Baseline low-density lipoprotein cholesterol (LDL-C), total cholesterol (TC), apolipoprotein B (apo B), and non-high density lipoprotein cholesterol (non-HDL-C) labs must be obtained prior to initiating treatment (required for renewal): AND
• Patient does not have heterozygous familial hypercholesterolemia (HeFH): AND

Universal Criteria

• Must be prescribed by, or in consultation with, a specialist in cardiology, lipidology, or endocrinology; AND

Homozygous Familial Hypercholesterolemia (HoFH)†

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

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 the following: severe hypersensitivity, etc.: **AND**
- Patient has had a reduction in LDL-C when compared to the initial baseline labs: **AND**
- Patient continues to adhere to diet and background lipid lowering therapy (e.g., statin, ezetimibe, PCSK9-I, lomitapide, LDL apheresis)

<table>
<thead>
<tr>
<th>If the patient is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, documentation of a causal relationship must be established between statin use and muscle symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Documentation must demonstrate that the patient experienced pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:</td>
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<tr>
<td>- Muscle symptoms resolve after discontinuation of statin: <strong>AND</strong></td>
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<tr>
<td>- Muscle symptoms occurred when re-challenged at a lower dose of the same statin: <strong>AND</strong></td>
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<tr>
<td>- Muscle symptoms occurred after switching to an alternative statin: <strong>AND</strong></td>
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<tr>
<td>- Documentation ruling out 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): <strong>OR</strong></td>
</tr>
<tr>
<td>- The patient has been diagnosed with rhabdomyolysis associated with statin use</td>
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<tr>
<td>- The diagnosis should be supported by acute neuromuscular illness or dark urine <strong>AND</strong> an acute elevation in creatine kinase (usually &gt; 5,000 IU/L or 5 times the upper limit of normal [ULN])</td>
</tr>
</tbody>
</table>

- Patient has been receiving stable background lipid lowering therapy for at least 4 weeks: **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 with a PSCK9 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); Ф Orphan Drug |

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

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
</tr>
</thead>
</table>
| Homozygous Familial Hypercholesterolemia (HoFH) | The recommended dose of Evkeeza is 15 mg/kg administered by intravenous (IV) infusion over 60 minutes 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:**
- J3590 – Unclassified biologics
- C9399 – Unclassified drugs or biologics, *(Hospital Outpatient Use Only)*

**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

Appendix 1 – Covered Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E78.00</td>
<td>Pure Hypercholesterolemia, unspecified</td>
</tr>
<tr>
<td>E78.01</td>
<td>Familial hypercholesterolemia</td>
</tr>
</tbody>
</table>

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: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Additional indications may be covered at the discretion of the health plan.
**Medicare Part B Administrative Contractor (MAC) Jurisdictions**

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

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/Article): N/A
Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We will:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact us at the phone number shown on the inside cover of this COC, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1. 866.631.5404 (TTY: 1.866.631.8597)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Language Assistance Services


Hindi: यदि आपके हिंदी बोलते हैं तो आपके लिए मुफ्त मदद की सहायता सेवाएं उपलब्ध हैं। 1-800-332-650 (TTY: 1.866.631.8597) पर कॉल करें।


Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY : 1.866.631.8597)

