

Evkeeza™ (evinacumab-dgnb)

When requesting Evkeeza™ (evinacumab-dgnb), the individual requiring treatment must be diagnosed with an FDA-approved indication and meet the specific coverage guidelines and applicable safety criteria for the covered indication.

FDA-approved Indication

Evkeeza is indicated as an adjunct to other low-density lipoprotein cholesterol (LDL-C) lowering therapies for the treatment of homozygous familial hypercholesterolemia (HoFH) in patients aged 5 years and older.

Coverage Guidelines

Homozygous Familial Hypercholesterolemia

The individual must meet **all** of the following criteria for approval:

- Is 5 years of age or older;
- Meets ONE of the following:
 - o Has phenotypic confirmation of homozygous familial hypercholesterolemia (e.g., pathogenic variants at the low-density lipoprotein receptor (LDLR), apolipoprotein B (apo B), proprotein convertase subtilisin kexin type 9 (PCSK9) or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene locus);

OR

- o Has an untreated LDL-C level > 400 mg/dL AND meets one of the following:
 - Had clinical manifestations of HoFH before the age of 10 years (i.e., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma); OR
 - At least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia (e.g., untreated LDL-C level ≥ 190 mg/dL and/or untreated total cholesterol level > 250 mg/dL);

OR

- o Has a treated LDL-C level ≥ 300 mg/dL AND meets one of the following:
 - Had clinical manifestations of HoFH before the age of 10 years (i.e., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma); OR
 - At least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia (e.g., untreated LDL-C level ≥ 190 mg/dL and/or untreated total cholesterol level > 250 mg/dL);
- Meets ONE of the following:

- o Meets all of the following:
 - Has tried one high-intensity statin therapy (i.e., atorvastatin $\geq$ 40 mg daily or rosuvastatin $\geq$ 20 mg daily [as a single-entity or as a combination product]); AND
 - Has tried one high-intensity statin along with ezetimibe (as a single-entity or as a combination product) for $\geq$ 8 continuous weeks; AND
 - The LDL-C level after this treatment regimen remains $\geq$ 70 mg/dL;

OR

- o Has been determined to be statin intolerant by meeting ONE of the following:
 - Has experienced statin-related rhabdomyolysis (*Note: rhabdomyolysis is associated with elevated creatine kinase levels at least 10 times the upper limit of normal, along with evidence of end organ damage which can include signs of acute renal injury [a $\geq$ 0.5 mg/dL increase in serum creatinine {SCr} levels or doubling of the SCr] and/or myoglobinuria [myoglobin present in urine]*); OR
 - Meets all of the following:
 - Has experienced skeletal-related muscle symptoms (i.e., myopathy or myalgia) that occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination products); AND
 - The skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin);
- Meets ONE of the following:
 - o Meets all of the following:
 - Has tried a PCSK9 inhibitor (i.e., Repatha or Praluent) for $\geq$ 8 continuous weeks; AND
 - The LDL-C level after this PCSK9 inhibitor therapy remains $\geq$ 70 mg/dL;

OR

- o Is known to have two LDL-receptor negative alleles; OR
- o Is 5 to 9 years of age;

The individual must meet the following criteria for reauthorization:

- Has experienced a response to therapy. (e.g. decreasing LDL-C, total cholesterol, non-high-density lipoprotein cholesterol, or apo B levels)
Note: An individual who is currently on therapy but has not been previously approved via eviCore coverage determination or is restarting therapy is reviewed under criteria for initial therapy.

Approval duration: 12 months

Dosing Guidelines

The recommended dose is 15 mg/kg administered by intravenous infusion once every 4 weeks.

References

1. Evkeeza™ injection for intravenous use [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals; March 2023.
2. Raal FJ, Rosenson RS, Reeskamp LF, et al, for the ELIPSE HoFH investigators. Evkeeza for homozygous familial hypercholesterolemia. *N Engl J Med.* 2020;383 (8):711-720.
3. Rosenson RS, Burgess LJ, Ebenbichler CF, et al. Evkeeza in patients with refractory hypercholesterolemia. *N Engl J Med.* 2020;383(24):2307-2319.
4. Raal FJ, Hovingh GK Catapano AL. Familial hypercholesterolemia treatments: guidelines and new therapies. *Atherosclerosis.* 2018;277:483-492.
5. Cuchel M, Bruckert E, Ginsberg HN, et al, for the European Atherosclerosis Society Consensus Panel on Familial Hypercholesterolemia. Homozygous familial hypercholesterolemia: new insights and guidance for clinicians to improve detection and clinical management. A positive paper from the Consensus Panel on Familial Hypercholesterolaemia of the European Atherosclerosis Society. *Eur Heart J.* 2014;35:2146-2157.
6. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. *J Am Coll.* 2022;80(14):1366-1418.