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Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

P&T Date: 06/11/2026

Evkeeza® (evinacumab-dgnb)

HCPCS: J1305

Policy:

Requests must be supported by submission of chart notes and patient specific documentation.

- A. Coverage of the requested drug is provided when all the following are met:
 - a. FDA approved indication
 - b. FDA approved age
 - c. Trial and therapeutic failure of one high-intensity statin
OR
 - d. History of statin-associated side effects or intolerance (e.g., skeletal muscle related symptoms) after a trial of two generic statins
OR
 - e. History of rhabdomyolysis after a trial of one statin
 - f. Trial and failure, contraindication, OR intolerance to the preferred drugs as listed in BCBSM/BCN's utilization management medical drug list.
- B. Quantity Limitations, Authorization Period and Renewal Criteria
 - a. Quantity Limit: Align with FDA recommended dosing
 - b. Authorization Period: One year at a time
 - c. Renewal Criteria: Clinical documentation must be provided to confirm that current criteria are met and that the medication is providing clinical benefit

***Note: Coverage and approval duration may differ for Medicare Part B members based on any applicable criteria outlined in Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) as determined by Center for Medicare and Medicaid Services (CMS). See the CMS website at <http://www.cms.hhs.gov/>. Determination of coverage of Part B drugs is based on medically accepted indications which have supported citations included or approved for inclusion determined by CMS approved compendia.

Background Information:

- Homozygous familial hypercholesterolemia (HoFH) is an ultra-rare inherited disease affecting approximately 1,300 patients in the United States. Patients with HoFH have mutations in the LDL receptor that result in virtually absent or impaired receptor-mediated catabolism of LDL cholesterol (LDL-C), leading to severely elevated LDL-C levels (> 400 mg/dL) and a lack of responsiveness to standard lipid-lowering therapies. Persistently elevated LDL-C increases the risk of premature atherosclerotic cardiovascular disease (ASCVD) and cardiac events in HoFH patients, often manifesting as early as the teenage years.
- HoFH can be diagnosed via genetic testing for causative mutations in the *LDLR*, *APOB*, and *PCSK9* genes, with *LDLR* mutations being the most common. Clinical diagnosis of HoFH can also be made in patients with an untreated LDL-C > 500 mg/dL or treated LDL-C $\geq$ 300 mg/dL, plus one of the following: cutaneous or tendon xanthoma prior to 10 years of age, or elevated LDL-C levels in both parents consistent with heterozygous familial hypercholesterolemia (HeFH). Of note, untreated LDL-C < 500 mg/dL may be present in some patients with HoFH; this may particularly be the case in young children and would warrant consideration of genetic testing to confirm or clarify the diagnosis.
- The 2026 guideline on the management of dyslipidemia, a report of the American College of Cardiology (ACC) and American Heart Association (AHA) joint committee on clinical practice guidelines, recommends treatment with maximally tolerated statin therapy for adults with clinical or genetic confirmation of HoFH to reduce risk of atherosclerotic cardiovascular disease (ASCVD). High intensity statins (atorvastatin 40 mg – 80 mg and rosuvastatin 20 mg – 40 mg) are expected to lower LDL-C by at least 50% and in clinical trials have been shown to provide greater ASCVD risk reduction than moderate intensity statins or placebo.
- If with a high-intensity statin the patient experiences statin-associated side effects that are not severe (e.g., myalgias), the statin dose can be reduced or alternate statins can be trialed with the ultimate goal of treating with a guideline-recommended maximally tolerated statin. There are a variety of generically available statins that can be dosed at different intensities or dosing regimens to help mitigate bothersome side effects; therefore, it is reasonable to require a trial of at least two statins in patients experiencing statin-associated side effects. Patients who experience more severe side effects with statin therapy (e.g. rhabdomyolysis) or recurrent statin-associated muscle symptoms despite multiple statin rechallenge attempts may need to discontinue statin use and transition to non-statin therapy that has been shown to provide clinical benefit.
- Due to the very high ASCVD risk in adults with HoFH and early occurrence of first major adverse cardiovascular event (MACE), aggressive LDL-C lowering is reasonable upon diagnosis; therefore, the addition of ezetimibe and/or PCSK9 monoclonal antibodies (i.e., Repatha® (evolocumab), Praluent® (alirocumab)) to maximally tolerated statin therapy may occur early on to lower LDL-C. If LDL-C levels remain $\geq$ 100 mg/dL despite maximally tolerated statin therapy, the 2026 guidelines recommend the addition of ezetimibe, PCSK9 monoclonal antibodies, and/or bempedoic acid to lower LDL-C. The preference of which agent to add may be influenced by the desired amount of LDL-C-lowering. Adding ezetimibe to statin therapy can lower LDL-C by an additional 13-20% while adding PCSK9 monoclonal antibodies may offer additional LDL-C reduction ranging from 43-64%.
- In adults with HoFH and an LDL -C $\geq$ 100 mg/dL despite maximally tolerated statins and the addition of ezetimibe and PCSK9 monoclonal antibodies, specialized therapies like Evkeeza, lomitapide, or LDL apheresis may be warranted to control LDL-C and, referral to a lipid specialist may be considered.
- For children and adolescents 8 years of age and older with an LDL-C $\geq$ 160 mg/dL and a clinical presentation consistent with familial hypercholesterolemia who do not respond adequately to 3 to 6 months of lifestyle therapy, the 2026 guidelines suggest initiation of a statin and other lipid-lowering therapies as necessary to lower LDL-C. Statins and other lipid-lowering therapies may be considered at younger ages (6 years) or at lower LDL-C cutpoints in the presence of concerning family history, extremely elevated LDL-C, pathogenic genetic variants, or other risk

conditions. Statin treatment intensity in children should be individualized to the child based on the severity of hypercholesterolemia and the needs of the child/family.

- Non-statin therapies approved for HoFH in children and adolescents include ezetimibe (10 years and older), Repatha (evolocumab; 10 years and older), and Evkeeza (evinacumab-dgnb).
- Evkeeza is a novel therapy for the treatment of HoFH, approved as an adjunct to other LDL-C-lowering therapies for both adults and pediatric patients 1 year of age and older. It is the first FDA-approved treatment that binds to and blocks angiopoietin-like 3 (ANGPTL3), a protein that aids in lipid metabolism. Due to the mutations affecting LDL receptor function, patients with HoFH are often less responsive or unresponsive to standard lipid-lowering therapies (e.g. statins, PCSK9 inhibitors) whose mechanism of action largely depend on up-regulating LDL receptor function. By inhibiting ANGPTL3, Evkeeza is able to significantly reduce LDL-C levels independent of LDL receptor function.
- The Phase III ELIPSE HoFH trial demonstrated that Evkeeza, when taken in addition to other lipid-lowering therapies (including maximally tolerated statins, PCSK9 inhibitors, ezetimibe, lomitapide, and LDL apheresis), reduced LDL-C by a statistically significant 49% after 24 weeks compared to a 2% increase with lipid-lowering therapies alone (placebo) in patients with HoFH. Similar LDL-C lowering effects were observed in even the most difficult-to-treat patients who were unresponsive to other therapies due to limited or absent LDL receptor function.
- Of note, the safety and efficacy of Evkeeza have not been established in patients with other causes of hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH). Additionally, the effects of Evkeeza on cardiovascular morbidity and mortality have not yet been determined; however, it has been established that lowering LDL-C confers a lowered cardiovascular risk that is proportional to the reduction in LDL-C levels.

References:

1. Blumenthal RS, Morris PB, Gaudino M, Johnson HM, Anderson TS, Bittner VA, Blankstein R, Brewer LC, Cho L, de Ferranti SD, Gianos E, Gluckman TJ, Gradney K, Isadinso I, Lloyd-Jones DM, Marrs JC, Martin SS, McLain KH, Mehta LS, Mora S, Mulugeta WM, Natarajan P, Navar AM, Orringer CE, Polonsky TS, Reynolds HR, Saseen JJ, Shapiro MD, Soffer DE, Tynes SA, Villavaso CD, Virani SS, Wilkins JT. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of dyslipidemia: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *J Am Coll Cardiol*. 2026
2. Bouhairie VE and Goldberg AC. Familial Hypercholesterolemia. *Cardiol Clin*. 2015 May; 33(2): 169-179. doi: 10.1016/j.ccl.2015.01.001.
3. De Ferranti SD. Familial hypercholesterolemia in children. In: UpToDate, Post, TW (Ed), UpToDate, Waltham, MA, 2021.
4. Evkeeza [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals Inc; September 2025.
5. Grundy SM, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *JACC Vol. 73, No. 24*. 2019: e285-e350. <https://doi.org/10.1016/j.jacc.2018.11.003>.
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7. Raal FJ et al. Evinacumab for Homozygous Familial Hypercholesterolemia. *N Engl J Med* 2020; 383: 711-20.
8. Raal FJ et al. Familial hypercholesterolemia treatments: Guidelines and new therapies. *Atherosclerosis* 277 (2018) 483-492.
9. Repatha [prescribing information]. Thousand Oaks, CA: Amgen Inc; August 2025.
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11. Rosenson RS and Durrington P. Familial hypercholesterolemia in adults: Treatment. In: UpToDate, Post, TW (Ed), UpToDate, Waltham, MA, 2021.

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12. Warden BA and Dell PB. Real-world evaluation of bempedoic acid use in patients with homozygous familial hypercholesterolemia. J of Clin Lipidology; 20 (1), 2026: 96-1003. <https://doi.org/10.1016/j.jacl.2025.10.065>

Policy History												
#	Date	Change Description										
2.0	Effective Date: 06/11/2026	Annual review of criteria was performed, no changes were made										
1.9	Effective Date: 06/05/2025	Annual review of criteria was performed, no changes were made										
1.8	Effective Date: 06/06/2024	Annual review of criteria was performed, no changes were made										
1.7	Effective Date: 06/08/2023	Annual review of criteria was performed, no changes were made										
1.6	Effective Date: 06/09/2022	Removed criteria requiring trial and failure of a preferred PCSK9 inhibitor; will leverage trial and failure of preferred criteria (bullet f) instead for flexibility										
1.5	Effective Date: 04/14/2022	Annual review of criteria was performed, no changes were made.										
1.4	Effective Date: 06/22/2021	UM medical management system update for BCNA and MAPPO <table><tr><th>Line of Business</th><th>PA Required in Medical Management System (Yes/No)</th></tr><tr><td>BCBS</td><td>Yes</td></tr><tr><td>BCN</td><td>Yes</td></tr><tr><td>MAPPO</td><td>Yes</td></tr><tr><td>BCNA</td><td>Yes</td></tr></table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	Yes	BCNA	Yes
Line of Business	PA Required in Medical Management System (Yes/No)											
BCBS	Yes											
BCN	Yes											
MAPPO	Yes											
BCNA	Yes											
1.3	Effective Date: 05/03/2021	UM medical management system update for BCBSM <table><tr><th>Line of Business</th><th>PA Required in Medical Management System (Yes/No)</th></tr><tr><td>BCBS</td><td>Yes</td></tr><tr><td>BCN</td><td>Yes</td></tr><tr><td>MAPPO</td><td>No</td></tr><tr><td>BCNA</td><td>No</td></tr></table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	Yes	BCN	Yes	MAPPO	No	BCNA	No
Line of Business	PA Required in Medical Management System (Yes/No)											
BCBS	Yes											
BCN	Yes											
MAPPO	No											
BCNA	No											
1.2	Effective Date: 04/08/2021	New Policy										
1.1	Effective Date: 04/05/2021	UM medical management system update for BCN <table><tr><th>Line of Business</th><th>PA Required in Medical Management System (Yes/No)</th></tr><tr><td>BCBS</td><td>No</td></tr><tr><td>BCN</td><td>Yes</td></tr><tr><td>MAPPO</td><td>No</td></tr><tr><td>BCNA</td><td>No</td></tr></table>	Line of Business	PA Required in Medical Management System (Yes/No)	BCBS	No	BCN	Yes	MAPPO	No	BCNA	No
Line of Business	PA Required in Medical Management System (Yes/No)											
BCBS	No											
BCN	Yes											
MAPPO	No											
BCNA	No											
1.0	Effective Date: 12/03/2020	Preliminary drug review										

* The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or <http://dailymed.nlm.nih.gov/dailymed/index.cfm>.

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Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form
Evkeeza™ (evinacumab-dgnb) HCPCS CODE: J1305



This form is to be used by participating physicians to obtain coverage for Evkeeza. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	Name
ID Number	Specialty
D.O.B. ☐ Male ☐ Female	Address
Pt weight (in kg) Date recorded: _____	City /State/Zip
Diagnosis	Phone/Fax: P: () - F: () -
Drug Name	NPI
Dose and Quantity	Contact Person
Directions	Contact Person Phone / Ext.
Date of Service(s)	

STEP 1: DISEASE STATE INFORMATION

- Is this request? ☐ Initiation ☐ Continuation *Date patient started therapy:* _____
- Please provide the NPI number for the place of administration: _____
- Initiation AND Continuation of therapy:**
 - Please check the patient's diagnosis: ☐ Homozygous familial hypercholesterolemia (HoFH)
☐ Other: _____
 - Has the patient tried and failed therapy with at least one high-intensity statin (for example: atorvastatin or rosuvastatin)?
☐ Yes, Please list: _____, Dose: _____
☐ No, Comment: _____
 - Does the patient have history of statin-associated side effects or intolerance (for example: skeletal muscle related symptoms) after a trial of two generic statins?
☐ Yes, Please list the names of the statins #1: _____; Date: _____; Side effect experienced: _____
Please list the names of the statins #2: _____; Date: _____; Side effect experienced: _____
☐ No, Comment: _____
 - Does the patient have history of rhabdomyolysis after a trial of one statin?
☐ Yes ☐ No, Comment: _____
 - Has the patient tried and failed therapy with Repatha?
☐ Yes ☐ No, Comment: _____
 - Will the patient be using Evkeeza in combination with PCSK9 (for example, Leqvio, Repatha, Praluent)?
☐ Yes ☐ No *Comment:* _____
- Continuation request:** Evkeeza start date: _____
 - Have the patient's signs and symptoms improved with Evkeeza?
☐ Yes ☐ No, Comment: _____

Please add any other supporting medical information necessary for our review

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name

Physician Signature

Date

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Attached labs
Step 3: Submit	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320

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4/8/2021; 12/27/2021; 6/9/2022, 10/5/2022