Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠ Medication Authorization Request Form

Evkeeza™ (evinacumab-dgnb) J3590

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐ Male ☐ Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Initiation or Continuation request for Evkeeza™? ☐ Initiation ☐ Continuation. Date of last infusion:_____
2. For what diagnosis is Evkeeza being prescribed? ☐ Homozygous familial hypercholesterolemia
   ☐ Other. Please specify._____
3. How was the diagnosis of Homozygous familial hypercholesterolemia confirmed?
   ☐ Genetic testing of the LDLR, APOB, and PCSK9. Attach documentation of genetic testing. ☐ Other. Please specify how the diagnosis was confirmed._____
4. What are the patient's most recent LDL-C levels? _____Date of last test? _____
5. Has the patient tried and failed a high-intensity statin?
   ☐ Yes. Which statin (dose and frequency)?_____ ☐ No
6. Does the patient have a contraindication or intolerance to statins?
   ☐ Yes. Please describe contraindication to statins: _____ ☐ No
7. Has the patient tried a PCSK9 inhibitor approved for use in homozygous familial hypercholesterolemia, such as Repatha? ☐ Yes. _____ ☐ No
8. Does the patient have a contraindication or intolerance to a PCSK9 inhibitor approved for the use in homozygous familiar hypercholesterolemia, such as Repatha?
   ☐ Yes. Please describe contraindication: _____ ☐ No
9. For Continuation therapy, Has the member demonstrated improvement since initiating Evkeeza therapy?
   ☐ Yes. _____ ☐ No

Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't 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	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	