Mass General Brigham
Health Plan

Evkeeza (evinacumab-dgnb)
Effective 08/01/2025

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Evkeeza (evinacimumab-dgnb) is an angiopoietin-like 3 (ANGPTL3) inhibitor indicated as an adjunct to other low-density lipoprotein-cholesterol (LDL-C) lowering therapies for the treatment of adult and pediatric patients, aged 5 years and older, with homozygous familial hypercholesterolemia (HoFH).

The safety and effectiveness of Evkeeza have not been established in patients with other causes of hypercholesterolemia, including those with heterozygous familial hypercholesterolemia (HeFH). Also, the effects of Evkeeza on cardiovascular morbidity and mortality have not been determined.

Coverage Guidelines
Authorization may be reviewed for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted when ALL the following criteria are met:

1. Documented diagnosis of homozygous familial hypercholesterolemia confirmed by ONE of the following:
    a. Laboratory test confirming genetic mutation associated with HoFH including low density lipoprotein receptor (LDLR) mutations
    b. PCSK9 mutations
    c. Familial defective apoB mutations
2. Member has a current LDL-C level of at least 70 mg/dL
3. Provider is a specialist or being used in collaboration with a specialist (e.g. cardiologist, endocrinologist, lipid lowering specialist, vascular neurologist)
4. Member meets ONE of the following:
    a. Paid claims or provider documentation that Evkeeza is being used as add-on therapy with a high intensity statin, ezetimibe, and PSCK9 inhibitor
    b. Contraindication or other compelling clinical rationale for omitting one or more of the following high intensity statin, ezetimibe, and PSCK9 inhibitor

5. Member is 5 years of age or older

Continuation of Therapy

Reauthorization will be granted when provider documents the following authorization criteria:

1. Member has achieved or maintained an LDL-C reduction
2. Member meets ONE of the following:
    a. Paid claims or provider documentation addressing adherence with a high intensity statin, ezetimibe, and PSCK9 inhibitor
    b. Contraindication or other compelling clinical rationale for omitting one or more of the following high intensity statin, ezetimibe, and PSCK9 inhibitor

Limitations

1. Initial approvals will be granted for 6 months
2. Reauthorizations will be granted for 12 months

References

1. 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;35:2146-2157.
2. Evkeeza (evinacumab-dgnb) [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals Inc.; March 2023.
3. Grundy SM, Stone NJ, Bailey, AL, Beam C, Birtcher KK, Blumenthal RS, Braun LT, de Ferranti S, Faiella-Tommasino J, Forman DE, Goldberg R, Heidenreich PA, Hlatky MA, Jones DW, Lloyd-Jones D, Lopez-Pajares N, Ndumele CE, Orringer CE, Peralta CA, Saseen JJ, Smith SC Jr, Sperling L, Virani SS, Yeboah J. 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. Circulation. 2019;139:e1082– e1143. DOI: 10.1161/CIR.0000000000000625.
4. Raal FJ, Rosenson RS, Reeskamp LF, et al. Evinacumab for homozygous familial hypercholesterolemia. N Engl J Med. 2020;383:711-20. DOI: 10.1056/NEJMoa2004215.

Review History

09/22/2021 – Created and Reviewed for Sept P&T. Effective 11/01/2021.
06/11/2025 – Reviewed and Updated at June P&T. Updated language for members who are new to the plan. Updated initial criteria to remove requirement for current weight and to lower minimum age from 12 to 5 years to align with FDA-approved labeling. Updated reauthorization criteria to remove example of LDL lowering. Effective 8/1/2025.