Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462 (800.88.CIGNA)

Evkeeza
(evinacumab-dgnb)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested: ☐ Evkeeza 345 mg/2.3 mL (150 mg/mL) vial ☐ Evkeeza 1,200 mg/8 mL (150 mg/mL) vial ☐ Other (please specify):

ICD10:

Directions for use: Dose: Quantity: Duration of therapy:
Weight (in kg):

Is the patient currently receiving Evkeeza or is this considered initial therapy? Note: If the patient is currently receiving the requested therapy but has not previously received approval of Evkeeza for this specific indication through Cigna, review under criteria for Initial Therapy. If the patient is restarting therapy with Evkeeza, Initial Therapy criteria must be met.
☐ Initial therapy
☐ Patient is currently receiving Evkeeza

(if Patient is currently receiving Evkeeza) Has the patient experienced a response to therapy according to the prescriber? Note: Examples of a response to therapy include decreasing low-density lipoprotein cholesterol (LDL-C), total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels. Yes ☐ No ☐

Where will this medication be obtained?
☐ Orsini Pharmaceutical Services
☐ Hospital Outpatient
☐ Other (please specify):
☐ Physician's office stock (billing on a medical claim form)

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Clinical Information:

****This drug requires supportive documentation (genetic testing, chart notes, lab/test results, etc). If this is an on-line request, supportive documentation for all answers must be attached with this request.**

What is your patient's diagnosis or reason for treatment?
☐ Homozygous Familial Hypercholesterolemia (HoFH)
☐ Heterozygous Familial Hypercholesterolemia (HeFH)
☐ Other Hyperlipidemia not associated with Homozygous Familial Hypercholesterolemia (HoFH) and is referred to as combined hyperlipidemia, hypercholesterolemia (pure, primary), dyslipidemia, or increased/elevated low-density lipoprotein cholesterol (LDL-C) levels
☐ other (please specify):

Does the patient have phenotypic confirmation of homozygous familial hypercholesterolemia? Note: Examples include 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 Yes ☐ No ☐

(if no phenotypic confirmation) Does the patient have an untreated low-density lipoprotein cholesterol (LDL-C) level greater than 400 mg/dL? Note: Untreated refers to prior to therapy with any antihyperlipidemic agent. Yes ☐ No ☐

(if no untreated LDL-C greater than 400mg/dL) Does the patient have a treated LDL-C level of at least 300 mg/dL? Note: Treated refers to after therapy with at least one antihyperlipidemic agent. Some examples of antihyperlipidemic agents include statins (for example, atorvastatin, rosuvastatin, lovastatin, simvastatin, pravastatin), ezetimibe, a PCSK9 inhibitor (that is, Repatha [evolocumab subcutaneous injection], Praluent [alirocumab subcutaneous injection]), or Juxtapid (lomitapide capsules). Yes ☐ No ☐

Did the patient have clinical manifestations of homozygous familial hypercholesterolemia before the age of 10 years? Note: Clinical manifestations of homozygous familial hypercholesterolemia are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma. Yes ☐ No ☐

(if no) Did at least one parent of the patient had untreated LDL-C levels or total cholesterol levels consistent with familial hypercholesterolemia? Note: An example of familial hypercholesterolemia is an untreated LDL-C level at least 190 mg/dL and/or an untreated total cholesterol level greater than 250 mg/dL. Yes ☐ No ☐

Has the patient experienced statin-related rhabdomyolysis? Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly 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 (noted by substantial increases in serum creatinine [Scr] levels [a 0.5 mg/dL or greater increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]). Yes ☐ No ☐

(if no statin-related rhabdomyolysis) Has the patient tried one high-intensity statin therapy (for example, atorvastatin at least 40 mg daily; rosuvastatin at least 20 mg daily [as a single entity or as a combination product])? Yes ☐ No ☐

if yes) Has the patient tried one high-intensity statin along with ezetimibe (as a single-entity or as a combination product) for at least 8 continuous weeks? Yes ☐ No ☐

(if yes) Did the patient's low-density lipoprotein cholesterol level after this treatment regimen remain at least 70 mg/dL? Yes ☐ No ☐

(if no rhabdo OR no high-intensity statin, high-intensity statin with ezetimibe, or LDL less than 70 mg/dL) Has the patient experienced skeletal-related muscle symptoms? Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness). Yes ☐ No ☐

(if yes) Did the patient's skeletal-muscle related symptoms occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product)? Yes ☐ No ☐

(if yes) Did the patient's skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin) after receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product)? Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia. Yes ☐ No ☐

(only answer if 10 years or older) Is the patient known to have two LDL-receptor negative alleles? Yes ☐ No ☐

(if no 2 LDL-receptor negative alleles) Has the patient tried one PCSK9 inhibitor for at least 8 continuous weeks? Note: Examples of PCSK9 inhibitors include Repatha (evolocumab subcutaneous injection) and Praluent (alirocumab subcutaneous injection). Yes ☐ No ☐

(if yes) Did the patient's LDL-C level after this PCSK9 inhibitor therapy remain at least 70 mg/dL? Yes ☐ No ☐

Is the requested dosing up to 15 mg/kg administered by intravenous infusion no more frequently than once every 4 weeks?

Yes ☐ No ☐

(if wrong dosing) Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Additional pertinent information *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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