

# Evkeeza® (Evinacumab-Dgnb)

**Policy Number:** 2024D00104G  
**Effective Date:** April 1, 2024

[➔ Instructions for Use](#)

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Related Commercial Policies
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## Coverage Rationale

[➔ See Benefit Considerations](#)

**Evkeeza (evinacumab-dgnb) is proven and medically necessary for the treatment of homozygous familial hypercholesterolemia (HoFH) patients who meet all of the following criteria:**

- For **initial therapy**, all of the following:
  - Diagnosis of HoFH by, or in consultation with, a lipid specialist (e.g., cardiologist, endocrinologist, lipid specialist/lipidologist) experienced in the management of HoFH; **and**
  - Confirmation of the HoFH diagnosis based on **one** of the following:
    - Submission of medical records (e.g., chart notes, laboratory values) confirming genetic confirmation of two mutant alleles at the *LDLR*, *APOB*, *PCSK9*, or *LDLRAP1* gene locus; **or**
    - **Both** of the following:
      - Pre-treatment LDL-C greater than 400 mg/dL
      - and**
      - **One** of the following:
        - Xanthoma before 10 years of age; **or**
        - Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents
- and**
- **One** of the following:
  - Patient is less than 10 years of age; **or**
  - Patient has failed to achieve an LDL-C goal of < 100 mg/dL despite **both** of the following:
    - **One** of the following (for Medicare reviews, refer to the [CMS](#) section\*):
      - Patient is currently treated with maximally tolerated statin therapy plus ezetimibe; **or**
      - Patient is unable to tolerate statin therapy as evidenced by **one** of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:
        - Myalgia [muscle symptoms without creatine kinase (CK) elevations]; **or**
        - Myositis (muscle symptoms with CK elevations < 10 times upper limit of normal [ULN]); **or**
        - Patient has a labeled contraindication to all statins as documented in medical records; **or**

- Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations > 10 times ULN

**and**

- **One** of the following (for Medicare reviews, refer to the [CMS](#) section\*):
  - Patient has been treated with PCSK9 therapy or did not respond to PCSK9 therapy; **or**
  - Physician attests that the patient is known to have two LDL-receptor negative alleles (little to no residual function) and therefore would not respond to PCSK9 therapy; **or**
  - Patient has a history of intolerance or contraindication to PCSK9 therapy; **or**
  - Patient has previously been treated with Juxtapid (lomitapide); **or**
  - Patient has previously been treated with lipoprotein apheresis

**and**

- Patient will continue other traditional low-density lipoprotein-cholesterol (LDL-C) lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza; **and**
- Evkeeza will not be used in combination with Juxtapid (lomitapide); **and**
- Evkeeza dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
- Initial authorization will be for no more than 12 months
- For **continuation of therapy**, **all** of the following:
  - Documentation of a positive clinical response to Evkeeza therapy; **and**
  - Evkeeza will not be used in combination with Juxtapid (lomitapide); **and**
  - Evkeeza dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
  - Reauthorization will be for no more than 12 months

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
J1305	Injection, evinacumab-dgnb, 5 mg

Diagnosis Code	Description
E78.01	Familial hypercholesterolemia
Z83.42	Family history of FH

## Background

Familial hypercholesterolemia (FH) is an autosomal hereditary disease with 3 major clinical features of 1) hyper-LDL cholesterol, 2) premature CAD and 3) tendon and skin xanthomas. FH is caused by pathogenic mutations in genes of the LDL receptor, apolipoprotein B-100 (Apo-B100) and proprotein convertase subtilisin/kexin type 9 (PCSK9) which play an important role in LDL receptor pathway. In homozygous familial hypercholesterolemia (HoFH), 2 pathogenic mutations are found in 2 alleles of the causative gene. Consequently, HoFH is characterized by markedly elevated levels of low-density lipoprotein cholesterol (LDL-C) and premature cardiovascular risk. The loss-of function variants in the LDL receptor causes low or zero clearance of LDL-C from circulation. HoFH affects approximately 1 in 300,000 people. If left untreated, mortality is common before age 30.

Evinacumab-dgnb is a recombinant human monoclonal antibody that binds and inhibits ANGPTL3.<sup>1</sup> ANGPTL3 is a regulator of lipoprotein metabolism, affecting lipoprotein lipase- and endothelial lipase-mediated hydrolysis of triglycerides and phospholipids. Inactivity of ANGPTL3 has been associated with potential for correcting hyperlipidemia.<sup>2,3</sup> Evinacumab-dgnb binds and blocks ANGPTL3 activity, thereby lowering TG and HDL-C by rescuing lipoprotein lipase and endothelial lipase

activities. Additionally, evinacumab-dgnb promotes very low-density lipoprotein (VLDL) processing and clearance upstream of LDL formation.

## Benefit Considerations

Some Certificates of Coverage allow for coverage of experimental/investigational/unproven treatments for life-threatening illnesses when certain conditions are met. The member specific benefit plan document must be consulted to make coverage decisions for this service. Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met. Where such mandates apply, they supersede language in the benefit document or in the medical or drug policy. Benefit coverage for an otherwise unproven service for the treatment of serious rare diseases may occur when certain conditions are met. Refer to the Policy and Procedure addressing the treatment of serious rare diseases.

## Clinical Evidence

Evinacumab-dgnb is 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).<sup>1</sup>

ELIPSE HoFH (NCT03399786), was a phase 3, randomized, double-blind, placebo-controlled trial, that evaluated the efficacy of evinacumab in HoFH patients. The study randomly assigned 65 patients, 12 years of age and older, with HoFH who were already stable on lipid-lowering therapy (e.g., maximally tolerated statins, ezetimibe, PCSK9 inhibitor antibodies, lomitapide, and lipoprotein apheresis), in a 2:1 ratio to receive evinacumab or placebo. Most of the trial patients (94%) were receiving a statin (a high-intensity statin in 77%). Additionally, a PCSK9 inhibitor was being administered in 77% of the patients, ezetimibe in 75%, and lomitapide in 25%; 34% of the patients were undergoing apheresis. A total of 63% of the patients were taking at least three lipid modifying drugs. 43 patients were randomized to receive evinacumab 15 mg/kg every 4 weeks and 22 patients to receive placebo. After the double-blind treatment period, 64 of 65 patients entered a 24-week open-label extension period where all patients received evinacumab 15 mg/kg IV every 4 weeks. The primary outcome was the percent change from baseline in the LDL cholesterol level at week 24. The mean baseline LDL-C was 255 mg/dL. At week 24, the relative risk reduction from baseline was 47.1% in those treated with evinacumab, compared to an increase of 1.9% in the placebo group for a between-group least-squares mean (LSM) difference of -49.0 percentage points (95% CI: -65.0, -33.1;  $p < 0.001$ ). The between-group LSM absolute difference in the LDL-C level was -132.1 mg/dL (95% CI: -175.3, -88.9;  $p < 0.001$ ).<sup>4</sup> The approval of Evkeeza for the expanded indication in patients aged 5 years and older was based on a three-part, single-arm, open-label study (NCT04233918) in 14 pediatric patients aged 5 to 11 years with HoFH.<sup>1</sup> Part B of this trial evaluated the efficacy of Evkeeza every 4 weeks as an adjunct to other lipid-lowering therapies (e.g., statins, ezetimibe, lomitapide, and lipoprotein apheresis) for 24 weeks. The primary endpoint was percent change in calculated LDL-C from baseline to week 24. At week 24, the mean percent change in calculated LDL-C from baseline was -48% (95% CI: -69% to -28%).

## Professional Societies

The European Atherosclerosis Society published in 2023 an updated consensus statement on homozygous familial hypercholesterolaemia (HoFH).<sup>9</sup> The 2023 statement updated criteria for the clinical diagnosis of HoFH, including that a low-density lipoprotein cholesterol (LDL-C)  $> 10$  mmol/L ( $> 400$  mg/dL) is suggestive of HoFH, requiring further evaluation, including a detailed medical and family history and/or genetic testing. Additional criteria for medical and family history include cutaneous or tendon xanthomas before age of 10 years and/or untreated elevated LDL-C levels consistent with heterozygous FH in both parents. Genetic criteria include genetic confirmation of bi-allelic pathogenic/likely pathogenic variants on different chromosomes at the *LDLR*, *APOB*, *PCSK9*, or *LDLRAP1* genes or  $\geq 2$  such variants at different loci.

The American College of Cardiology/American Heart Association Task Force published their clinical practice guidelines for the management of blood cholesterol in 2018. In regards to those with severe hypercholesterolemia (LDL-C  $\geq 190$  mg/dL), the guideline recommends:<sup>5</sup>

- In patients 20 to 75 years of age with an LDL-C level of 190 mg/dL or higher ( $\geq 4.9$  mmol/L) maximally tolerated statin therapy is recommended (Level I; B-R)
- In patients 20 to 75 years of age with an LDL-C level of 190 mg/dL or higher ( $\geq 4.9$  mmol/L) who achieve less than a 50% reduction in LDL-C while receiving maximally tolerated statin therapy and/or have an LDL-C level of 100 mg/dL or higher ( $\geq 2.6$  mmol/L) ezetimibe therapy is reasonable (Level IIa; B-R)

- In patients 20 to 75 years of age with a baseline LDL-C level 190 mg/dL or higher ( $\geq 4.9$  mmol/L), who achieve less than a 50% reduction in LDL-C levels and have fasting triglycerides 300 mg/dL or lower ( $\leq 3.4$  mmol/L) while taking maximally tolerated statin and ezetimibe therapy, the addition of a bile acid sequestrant may be considered (Level IIb; B-R)
- In patients 30 to 75 years of age with heterozygous FH and with an LDL-C level of 100 mg/dL or higher ( $\geq 2.6$  mmol/L) while taking maximally tolerated statin and ezetimibe therapy, the addition of a PCSK9 inhibitor may be considered (Level IIb; B-R)
- In patients 40 to 75 years of age with a baseline LDL-C level of 220 mg/dL or higher ( $\geq 5.7$  mmol/L) and who achieve an on-treatment LDL-C level of 130 mg/dL or higher ( $\geq 3.4$  mmol/L) while receiving maximally tolerated statin and ezetimibe therapy, the addition of a PCSK9 inhibitor may be considered (Level IIb; C-LD)

Per a 2022 ACC Expert Consensus Decision Pathway (ECDP), specialized therapies, such as evinacumab or lomitapide, may be needed to control LDL-C in patients with HoFH who have an inadequate response to statins with or without ezetimibe and PCSK9 inhibitors.<sup>8</sup> In the opinion of the writing committee for the ECDP, these therapies are best administered under the care of a lipid specialist.

The Hyperlipidaemia Education and Atherosclerosis Research Trust United Kingdom (HEART UK) published a consensus statement on a strategy for managing HoFH in the UK and treating to lower lipid targets suggested by the European Atherosclerosis Society (EAS) in 2017. The recommended target LDL-C is  $< 2.5$  mmol/L in adults ( $< 1.8$  mmol/L if CVD) and  $< 3.5$  mmol/L in children. With regards to treatment of HoFH, the consensus statement recommends the following:<sup>6</sup>

- Aged 12 and under: Consider lipid apheresis from the age of 2 and no later than 8, combined with maximum tolerated statin, ezetimibe, and bile acid sequestrants (BAS) (if effective)
- Aged over 12: Consider lipid apheresis and evolocumab, unless known LDLR negative, together. Apheresis frequency may be discontinued, be less frequent or not started
- All patients should be offered maximum doses of atorvastatin or rosuvastatin combined with ezetimibe. Other statins may be tried in the event of intolerance
- All HoFH patients on apheresis and standard drug treatment with LDL-C above target, who are receptor defective, should have a trial of treatment with evolocumab
- Homozygotes or compound heterozygotes with gain of function PCSK9 alleles or double heterozygotes with, for example, an LDLR defective allele and a gain of function PCSK9 allele (digenic) are likely to respond well to PCSK9 inhibition
- Patients who respond with 10-15% reduction in LDL-C (or interval mean LDL-C if on lipid apheresis) should continue treatment
- Evolocumab should be injected subcutaneously directly after apheresis
- Lomitapide should be considered for adults with HoFH, who have failed to achieve treatment targets while on apheresis and standard drug treatment and have had a trial of evolocumab
- The frequency of lipid apheresis may be reduced when combined with lomitapide and/or evolocumab

The Japan Atherosclerosis Society and Asian Pacific Society of Atherosclerosis and Vascular Diseases published guidelines for diagnosis and treatment of familial hypercholesterolemia in 2017. With regards to treatment of HoFH, the guideline recommends the following:<sup>7</sup>

- Intensive lipid-lowering therapy is necessary for the treatment of FH, first-line drug should be statins (recommendation level A, evidence level 3)
- For homozygous FH, consider LDL apheresis and treatment with PCSK9 inhibitors or (microsomal triglyceride protein inhibitor) MTP inhibitors (recommendation level A)

## U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Evkeeza 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).<sup>1</sup> The safety and effectiveness of Evkeeza have not been established in patients with other causes of hypercholesterolemia, including those with heterozygous familial hypercholesterolemia (HeFH). The effects of Evkeeza on cardiovascular morbidity and mortality have not been determined.

# Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) for Evkeeza® (evinacumab-dgnb). Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.

In general, Medicare may cover outpatient (Part B) drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. Refer to the [Medicare Benefit Policy Manual, Chapter 15, §50 - Drugs and Biologicals](#). (Accessed March 10, 2023)

\*Preferred therapy criteria is not applicable for Medicare Advantage members.

## References

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3. Adam RC, Mintah IJ, Alexa-Braun CA, et al. Angiopoietin-like protein 3 governs LDL-cholesterol levels through endothelial lipase-dependent VLDL clearance. *J Lipid Res*. 2020;61(9):1271-1286. doi:10.1194/jlr.RA120000888.
4. Raal FJ, Rosenson RS, Reeskamp LF, et al. Evinacumab for Homozygous Familial Hypercholesterolemia. *N Engl J Med*. 2020;383(8):711-720. doi:10.1056/NEJMoa2004215.
5. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: Executive Summary: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines.
6. France M, Rees A, Datta D, et al. HEART UK statement on the management of homozygous familial hypercholesterolaemia in the United Kingdom. *Atherosclerosis*. 2016;255:128-139. doi:10.1016/j.atherosclerosis.2016.10.017.
7. Harada-Shiba M, Arai H, Ishigaki Y, et al. Guidelines for Diagnosis and Treatment of Familial Hypercholesterolemia 2017. *J Atheroscler Thromb*. 2018;25(8):751-770. doi:10.5551/jat.CR003.
8. Writing Committee, Lloyd-Jones DM, Morris PB, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Solution Set Oversight Committee [published correction appears in *J Am Coll Cardiol*. 2023 Jan 3;81(1):104]. *J Am Coll Cardiol*. 2022;80(14):1366-1418. doi:10.1016/j.jacc.2022.07.006.
9. Cuchel M, Raal FJ, Hegele RA, et al. 2023 Update on European Atherosclerosis Society Consensus Statement on Homozygous Familial Hypercholesterolaemia: new treatments and clinical guidance. *Eur Heart J*. 2023;44(25):2277-2291. doi:10.1093/eurheartj/ehad197.

## Policy History/Revision Information

Date	Summary of Changes
04/01/2024	<p><b>Coverage Rationale</b></p> <ul style="list-style-type: none"><li>Revised coverage criteria for: <b>Initial Therapy</b></li></ul> <ul style="list-style-type: none"><li>Removed criterion requiring confirmation of the hypercholesterolemia (HoFH) diagnosis based on submission of medical records (e.g., chart notes, laboratory values) confirming [the patient has a] treated LDL-C greater than 300 mg/dL or history of treatment with Juxtapid (lomitapide)</li><li>Replaced criterion requiring:<ul style="list-style-type: none"><li>“Confirmation of the HoFH diagnosis based on <i>submission of medical records (e.g., chart notes, laboratory values) confirming</i> [the patient has] a pre-treatment LDL-C greater than 500 mg/dL” with “confirmation of the HoFH diagnosis based on a pre-treatment LDL-C greater than 400 mg/dL”</li></ul></li></ul>

Date	Summary of Changes
	<ul style="list-style-type: none"> <li>▪ “Confirmation of the HoFH diagnosis based on heterozygous familial hypercholesterolemia (HeFH) in both parents” with “confirmation of the HoFH diagnosis based on <i>evidence of</i> heterozygous familial hypercholesterolemia (HeFH) in both parents”</li> <li>○ Changed duration for initial authorization from “no more than <b>6</b> months” to “no more than <b>12</b> months”</li> </ul> <p><b>Continuation of Therapy</b></p> <ul style="list-style-type: none"> <li>○ Removed criterion requiring <b>one</b> of the following: <ul style="list-style-type: none"> <li>▪ Patient is less than 10 years of age</li> <li>▪ Patient continues treatment with other traditional low-density lipoprotein-cholesterol (LDL-C) lowering therapies (e.g., statin, ezetimibe) in combination with Evkeeza</li> </ul> </li> <li>○ Replaced criterion requiring “documentation of a positive clinical response to therapy <i>from pre-treatment baseline</i>” with “documentation of a positive clinical response to <i>Evkeeza</i> therapy”</li> </ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"> <li>● Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information</li> <li>● Archived previous policy version 2023D00104F</li> </ul>

## Instructions for Use

This Medical Benefit Drug Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Benefit Drug Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Benefit Drug Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Benefit Drug Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.