Evkeeza™ (evinacumab-dgnb) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Cardiologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Evkeeza (evinacumab-dgnb) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient have a documented diagnosis of homozygous familial hypercholesterolemia?

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Does the patient possess mutations in two alleles at the *LDLR, APOB, PCSK9* or *LDLRAP1* gene locus?

→ Please indicate patient's untreated (i.e., before treatment with any lipid lowering therapy) total cholesterol level: _____ mg/dL ☐ Unknown

Please indicate patient's treated (i.e., after initiation of lipid-lowering therapy but before treatment with the requested drug) LDL-C: _____ mg/dL ☐ Unknown

Please indicate if patient has either of the following:

☐ Presence of cutaneous or tendinous xanthomas before the age of 10 years

☐ An untreated LDL-C level of greater than or equal to 190 mg/dl in both parents

☐ Neither- The patient does not meet any of the criteria listed above

☐ Unknown

☐ Yes ☐ No Does the patient have clinical atherosclerotic cardiovascular disease (ASCVD) (e.g., myocardial infarction, acute coronary syndromes, coronary or other arterial revascularization procedure [e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery])?

Prior to initiation of treatment with the requested medication, please indicate the patient's LDL-C level: _____ mg/dL Date obtained: _____/_____/_____

☐ Yes ☐ No Prior to initiation of treatment with the requested drug, is/was the patient receiving stable treatment with at least 3 lipid-lowering therapies (for example, statins, ezetimibe, PCSK9 directed therapy) at the maximum tolerated dose?

☐ Yes ☐ No Will the patient continue to receive concomitant lipid-lowering therapy?

For Continuation Requests (clinical documentation required for all requests):

Please indicate the current LDL-C level: _____ Date obtained: _____/_____/_____

☐ Yes ☐ No Has the patient achieved or maintained an LDL-C reduction as evidenced by LDL-C is now at goal?

→ ☐ Yes ☐ No Has the patient achieved or maintained an LDL-C reduction as evidenced by at least 40% reduction of LDL-C from baseline?

☐ Yes ☐ No Is the patient currently receiving concomitant lipid-lowering therapy?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** _____/_____/_____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.