



Prior Authorization

Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Repatha® (evolocumab injection for subcutaneous use [single-use prefilled syringes and Pushtronex™ system])

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Product Identifier(s)

51881

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

NPF Coverage Policy

Cigna covers evolocumab (Repatha®) as medically necessary when the following criteria are met for FDA Indications or Other Uses with Supportive Evidence:

Prior Authorization is recommended for prescription benefit coverage of Repatha. All approvals are provided for the duration noted below. Due to the specialized skills required for evaluation and monitoring, approval requires Repatha to be prescribed by or in consultation with a physician who specializes in the condition being treated.

FDA Indication(s)

- Atherosclerotic Cardiovascular Disease [Clinical].*** Approve for 3 years if the individual meets the following criteria (A, B, C, and D):
 - Individual is ≥ 18 years of age; AND
 - Individual has had one of the following conditions or diagnoses (i, ii, iii, iv or v):

- i. A previous myocardial infarction or a history of an acute coronary syndrome; OR
- ii. Angina (stable or unstable); OR
- iii. A past history of stroke or transient ischemic attack; OR
- iv. Peripheral arterial disease; OR
- v. Individual has undergone a coronary or other arterial revascularization procedure in the past; AND
Note: Examples include coronary artery bypass graft surgery, percutaneous coronary intervention, angioplasty, and coronary stent procedures.

C) Individual meets one of the following criteria (i or ii):

- i. Individual meets both of the following (a and b):
 - a) Individual has tried one high-intensity statin therapy (i.e., atorvastatin \geq 40 mg daily; rosuvastatin tablets \geq 20 mg daily [as a single-entity or as a combination product]) for \geq 8 continuous weeks; AND
 - b) Low-density lipoprotein cholesterol level after this treatment remains \geq 70 mg/dL; OR
- ii. Individual has been determined to be statin intolerant by meeting one of the following criteria (a or b):
 - a) Individual experienced statin-related rhabdomyolysis; OR
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 \geq 0.5 mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR
 - b) Individual meets all of the following [(1), (2), and (3)]:
 - (1) Individual experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
 - (2) The skeletal-related muscle symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products); AND
 - (3) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); AND
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.

D) Medication is prescribed by, or in consultation with, a cardiologist; an endocrinologist; or a physician who focuses in the treatment of cardiovascular (CV) risk management and/or lipid disorders.

2. Heterozygous Familial Hypercholesterolemia (HeFH).* Approve for 3 years if the individual meets the following criteria (A, B, C, and D):

- A) Individual is \geq 18 years of age; AND**
- B) Individual meets one of the following criteria (i, ii, or iii):**
 - i. Individual has an untreated low-density lipoprotein cholesterol (LDL-C) \geq 190 mg/dL (prior to treatment with antihyperlipidemic agents); OR
 - ii. Individual has genetic confirmation of HeFH by mutations in the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9, or low-density lipoprotein receptor adaptor protein 1 gene; OR
 - iii. Individual has been diagnosed with HeFH meeting one of the following diagnostic criteria thresholds (a or b):
 - a) Individual meets both of the following [(1) and (2)]:
 - (1) Prescriber used the Dutch Lipid Network criteria to diagnose HeFH; AND
 - (2) Individual had a score $>$ 5; OR
 - b) Individual meets both of the following [(1) and (2)]:
 - (1) Prescriber used the Simon Broome criteria to diagnose heterozygous familial hypercholesterolemia; AND
 - (2) Individual met the threshold for “definite” or “possible (or probable)” familial hypercholesterolemia; AND
- C) Individual meets one of the following criteria (i or ii):**
 - i. Individual meets both of the following criteria (a and b):

- a) Individual has tried one high-intensity statin therapy (i.e., atorvastatin \geq 40 mg daily; rosuvastatin tablets \geq 20 mg daily [as a single-entity or as a combination product]) for \geq 8 continuous weeks; AND
- b) LDL-C level after this treatment remains \geq 70 mg/dL; OR
- ii. Individual has been determined to be statin intolerant by meeting one of the following criteria (a or b):
 - a) Individual experienced statin-related rhabdomyolysis; OR
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 [$a \geq 0.5$ mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR
 - b) Individual meets all of the following [(1), (2), and (3)]:
 - (1) Individual experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
 - (2) The skeletal-related muscle symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products); AND
 - (3) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); AND
Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia.
- D) Medication is prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders.

3. Homozygous Familial Hypercholesterolemia (HoFH).* Approve for 3 years if the individual meets the following criteria (A, B, C, and D):

- A) Individual is \geq 13 years of age; AND
- B) Individual meets one of the following (i, ii, or iii):
 - i. Individual has genetic confirmation of two mutant alleles at the low-density lipoprotein receptor, apolipoprotein B, proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 gene locus; OR
 - ii. Individual has an untreated low-density lipoprotein (LDL-C) level $>$ 500 mg/dL AND meets one of the following (a or b):
Note: Untreated refer to therapy with any antihyperlipidemic agent.
 - a) Individual had clinical manifestations of HoFH before 10 years of age; OR
Note: Clinical manifestations of HoFH are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas, or xanthelasma.
 - b) Both parents of the individual had untreated LDL-C levels or total cholesterol levels consistent with heterozygous familial hypercholesterolemia (HeFH); OR
Note: An example of HeFH in both parents would be if both had an untreated LDL-C level \geq 190 mg/dL and/or an untreated total cholesterol level $>$ 250 mg/dL.
 - iii. Individual has a treated LDL-C level \geq 300 mg/dL AND meets one of the following (a or b):
Note: Treated refers to after therapy with at least one antihyperlipidemic agent. Some examples of antihyperlipidemic agents include statins (e.g., atorvastatin, rosuvastatin, lovastatin, simvastatin, pravastatin), ezetimibe, a PCSK9 inhibitor (e.g., Praluent [alirocumab injection for subcutaneous use]), Evkeeza (evinacumab-dgnb injection for intravenous use), or Juxtapid (lomitapide capsules).
 - a) Individual had clinical manifestations of HoFH before 10 years of age; OR
Note: Examples of clinical manifestations of HoFH are cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma.
 - b) Both parents of the individual had untreated LDL-C levels or total cholesterol levels consistent with HeFH; AND
Note: An example of HeFH in both parents would be if both had an untreated LDL-C \geq 190 mg/dL and/or an untreated total cholesterol $>$ 250 mg/dL.
- C) Individual meets one of the following criteria (i or ii):
 - i. Individual meets both of the following (a and b):

- a) Individual has tried one high-intensity statin therapy (i.e., atorvastatin \geq 40 mg daily; rosuvastatin \geq 20 mg daily [as a single-entity or as a combination product]) for \geq 8 continuous weeks; AND
- b) LDL-C level after this treatment remains \geq 70 mg/dL; OR
- ii. Individual has been determined to be statin intolerant by meeting one of the following criteria (a or b):
 - a) Individual experienced statin-related rhabdomyolysis; OR
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 [$a \geq 0.5$ mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR
 - b) Individual meets all of the following criteria [(1), (2), and (3)]:
 - (1) Individual experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
 - (2) The skeletal-related muscle symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products); AND
 - (3) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); AND
Note: Examples of skeletal-related muscle symptoms include myopathy or myalgia.
- D) Medication is prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders.

4. Primary Hyperlipidemia.* Approve for 3 years if the individual meets the following criteria (A, B, C, and D):
Note: This is not associated with atherosclerotic cardiovascular disease (ASCVD), heterozygous familial hypercholesterolemia (HeFH), or homozygous familial hypercholesterolemia (HoFH) and may be referred to as combined hyperlipidemia, hypercholesterolemia (pure, primary), dyslipidemia, or increased/elevated low-density lipoprotein cholesterol (LDL-C) levels.

- A) Individual is \geq 18 years of age; AND
- B) Individual has a coronary artery calcium or calcification score \geq 300 Agatston units; AND
- C) Individual meets one of the following criteria (i or ii):
 - i. Individual meets all of the following criteria (a, b, and c):
 - a) Individual has tried one high-intensity statin therapy (i.e., atorvastatin \geq 40 mg daily; rosuvastatin tablets \geq 20 mg daily [as a single-entity or as a combination product]); AND
 - b) Individual has tried one high-intensity statin therapy above along with ezetimibe (as a single-entity or as a combination product) for \geq 8 continuous weeks; AND
 - c) LDL-C level after this treatment regimen remains \geq 100 mg/dL; OR
 - ii. Individual has been determined to be statin intolerant by meeting one of the following criteria (a or b):
 - a) Individual experienced statin-related rhabdomyolysis; OR
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 [$a \geq 0.5$ mg/dL increase in Scr or doubling of the Scr] and/or myoglobinuria [myoglobin present in urine]); OR
 - b) Individual meets all of the following [(1), (2), and (3)]:
 - (1) Individual experienced skeletal-related muscle symptoms; AND
Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
 - (2) The skeletal-related muscle symptoms occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products); AND
 - (3) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) the skeletal-related muscle symptoms resolved upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin); AND
Note: Examples of skeletal-related muscle symptoms include myopathy or myalgia.

- D) Medication is prescribed by or in consultation with a cardiologist, an endocrinologist, or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders.

Note:

* A individual may have a diagnoses that pertain to more than one FDA-approved indication, therefore, consider review under different approval conditions, if applicable (e.g., a individual with heterozygous familial hypercholesterolemia or homozygous familial hypercholesterolemia may have had a clinical ASCVD event, a individual with primary hyperlipidemia may have heterozygous familial hypercholesterolemia).

Conditions Not Covered

Evolocumab (Repatha®) is considered experimental, investigational or unproven for ANY other use including the following (this list may not be all inclusive):

1. **Concurrent use of Repatha with Praluent (alirocumab injection for subcutaneous use).** Praluent is another PCSK9 inhibitor and should not be used with Repatha.²

Background

Overview

Repatha, a proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor antibody, is indicated for the following uses:¹

- **Established cardiovascular (CV) disease**, in adults to reduce the risk of myocardial infarction (MI), stroke, and coronary revascularization.
- **Primary hyperlipidemia (including heterozygous familial hypercholesterolemia [HeFH])**, in adults as an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe) to reduce low-density lipoprotein cholesterol (LDL-C).
- **Homozygous familial hypercholesterolemia (HoFH)**, as an adjunct to diet and other low-density lipoprotein (LDL)-lowering therapies (e.g., statins, ezetimibe, LDL apheresis) in patients who require additional lowering of LDL-C.

The safety and effectiveness of Repatha have not been established in pediatric patients with primary hyperlipidemia or HeFH. The safety and effectiveness of Repatha have not been established in pediatric patients with HoFH < 13 years of age.¹ Another PCSK9 inhibitor that is available is Praluent® (alirocumab injection for subcutaneous use).²

Guidelines

Many guidelines are available regarding the treatment of patients with dyslipidemia.³⁻¹⁰ For patients with elevated LDL-C, statins are the cornerstone of therapy and recommended first-line to be used at maximally tolerated doses due to the established benefits regarding the reduction of CV risks. Atorvastatin 40 mg to 80 mg once daily (QD) and rosuvastatin 20 mg to 40 mg QD are considered high-intensity statins as they achieve LDL-C lowering of ≥ 50%. Ezetimibe is usually the next therapy added.

- The **American Heart Association/American College of Cardiology guidelines on the management of blood cholesterol** (2018) defines atherosclerotic cardiovascular disease (ASCVD) as an acute coronary syndrome (ACS), those with a history of myocardial infarction (MI), stable or unstable angina or coronary or other revascularizations, stroke, transient ischemic attack (TIA), or peripheral arterial disease. Although LDL-C thresholds are not always recognized, in general, an LDL-C < 70 mg/dL is recommended for most patients with ASCVD to reduce CV risk. Use of a PCSK9 as an adjunct is justified if this goal is not met with maximally tolerated statins.¹⁰ Additionally, guidelines and reviews have recognized that patients with a coronary artery calcium or calcification score ≥ 300 Agatston units are at an increased risk of CV events.¹⁰⁻¹³
- The **National Lipid Association published guidelines for the screening, diagnosis, and management of pediatric and adult patients with familial hypercholesterolemia** (2011).⁸ Genetic testing can identify HoFH and HeFH in some cases. Also, HeFH can be diagnosed utilizing Simon Broome criteria or Dutch Lipid Clinical Network criteria. Patients with an untreated LDL-C ≥ 190 mg/dL

suggest familial hypercholesterolemia. Statins are the initial treatment for all adults with familial hypercholesterolemia, usually at high-potency doses. Ezetimibe can also be added. In general, for patients with HeFH who have not yet manifested ASCVD, LDL-C levels ≤ 100 mg/dL are recommended. Other guidelines and reviews note that the addition of a PCSK9 inhibitor to a statin plus ezetimibe regimen can be considered if this goal is not achieved.^{5,9}

- The **2014 HoFH position paper from the Consensus Panel on familial hypercholesterolemia of the European Atherosclerosis Society** states the diagnosis of HoFH is made based on genetic or clinical criteria.¹⁴ A definitive diagnosis can be made by genetic confirmation of two mutant alleles at the low density lipoprotein receptor, apolipoprotein B, PCSK9, or low-density lipoprotein receptor adaptor protein 1 gene locus. However, in some patients genetic confirmation remains elusive. Historically, HoFH has been commonly diagnosed based on LDL-C levels such as an untreated LDL-C > 500 mg/dL, or a treated LDL-C ≥ 300 mg/dL. Also confirming the diagnosis is the presence of xanthomas (cutaneous or tendinous) before the age of 10 years or a family history of elevated LDL-C levels consistent with HeFH in both parents. Other clinical manifestations of HoFH include arcus cornea or xanthelasma. Initial therapy for HoFH are high-intensity statins.¹⁴ Other guidelines note that ezetimibe and PCSK9 inhibitors can be added if further reductions are needed; Juxtapid can be considered.^{5,10}

References

1. Repatha® injection for subcutaneous use [prescribing information]. Thousand Oaks, CA: Amgen; February 2021.
2. Praluent® injection for subcutaneous use [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals; April 2021.
3. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice guidelines. *Circulation*. 2014;129(25 Suppl 2):S1-S45. Available at <http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a>. Accessed on April 1, 2021.
4. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statins for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk. *J Am Coll Cardiol*. 2016;68(1):92-125.
5. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statins for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease. *J Am Coll*. 2017;70(14):1785-1822.
6. Jacobson TA, Ito MK, Maki KC, et al. National Lipid Association recommendations for patient-centered management of dyslipidemia: Part 1-executive summary. *J Clin Lipidol*. 2014;8:473-488. Available at: [http://www.lipidjournal.com/article/S1933-2874\(14\)00274-8/pdf](http://www.lipidjournal.com/article/S1933-2874(14)00274-8/pdf). Accessed on April 1, 2021.
7. Jacobson TA, Ito MK, Maki KC, et al. National Lipid Association recommendations for patient-centered management of dyslipidemia: Part 1-full report. *J Clin Lipidol*. 2015;9:129-169. Available at: [http://www.lipidjournal.com/article/S1933-2874\(15\)00059-8/pdf](http://www.lipidjournal.com/article/S1933-2874(15)00059-8/pdf). Accessed on April 1, 2021.
8. Goldberg AC, Hopkins PN, Toth PP, et al. Familial hypercholesterolemia: screening, diagnosis and management of pediatric and adult patients. *J Clin Lipidol*. 2011;5:S1-S8.
9. Orringer CE, Jacobson TA, Saseen JJ, et al. Update on the use of PCSK9 inhibitors in adults: recommendations from an Expert Panel of the National Lipid Association. *J Clin Lipid*. 2017;11:880-890. Available at: [http://www.lipidjournal.com/article/S1933-2874\(17\)30290-8/pdf](http://www.lipidjournal.com/article/S1933-2874(17)30290-8/pdf). Accessed on April 1, 2021.
10. Grundy SM, Stone NJ, Bailey AL, et al. 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. Available at: <https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000625>. Accessed on April 1, 2021.
11. Hect HS, Cronin P, Blaha M, et al. 2016 SCCT/STR guidelines for coronary artery calcium scoring of noncontrast noncardiac chest CT scans: A report of the Society of Cardiovascular Computed Tomography and Society of Thoracic Radiology. *J Thorac Imaging*. 2017;32(5):W54-S66.
12. Blaha MJ, Mortensen MB, Kianoush S, et al. Coronary artery calcium scoring. Is it time for a change in methodology. *J Am Coll Cardiol Imag*. 2017;10:923-937.

13. Burge MR, Eaton RP, Comerchi G, et al. Management of asymptomatic patients with positive coronary artery calcium scans. *J Endocr Soc.* 2017;1(6):588-599.
14. Cuchel M, Bruckert E, Ginsberg HN, et al, for the European Atherosclerosis Society Consensus Panel on Familial Hypercholesterolemia. 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.
15. Haase A, Goldberg AC. Identification of people with heterozygous familial hypercholesterolemia. *Curr Opin Lipidol.* 2012;23:282-289.
16. Gidding SS, Champagne MA, de Ferranti SD, et al. The agenda for familial hypercholesterolemia. A scientific statement from the American Heart Association. *Circulation.* 2015;132(22):2167-2192.

Revision History

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	<p>The following changes were made:</p> <ol style="list-style-type: none"> 1. Atherosclerotic Cardiovascular Disease: To the criteria that the patient have skeletal-related muscle symptoms resolve upon discontinuation of atorvastatin and rosuvastatin, examples of skeletal-related muscle symptoms (myopathy and myalgia) were added as a Note. 2. HeFH: The diagnostic criteria that the patient has a treated LDL-C level ≥ 100 mg/dL (after treatment with antihyperlipidemic agents but prior to PCSK9 inhibitor therapy such as Praluent [alirocumab injection for subcutaneous use] or Repatha [evolocumab injection for subcutaneous use]) were removed. Also, the diagnostic criteria that the patient has clinical manifestations of HeFH were removed. For the diagnostic Simon Broome criteria, the word “probable” was added for meeting the threshold of “possible” familial hypercholesterolemia (written as “possible [or probable]”). To the criteria that the patient have skeletal-related muscle symptoms resolve upon discontinuation of atorvastatin and rosuvastatin, examples of skeletal-related muscle symptoms (myopathy and myalgia) were added as a Note. 3. HoFH: The diagnostic criteria for HoFH were revised (current criteria Bii and Biii). To the criteria which stated that the patient has clinical manifestation of HoFH, the qualifier of “before the age of 10 years” was added. Also, this criterion is no longer an independent diagnostic but is now one of two criteria that must be met under the LDL-C threshold requirements (i.e., that the patient has an untreated LDL-C level > 500 mg/dL or a treated LDL-C ≥ 300 mg/dL). An additional criterion added to the two LDL-C threshold requirements is that the parents of the patient had untreated LDL-C levels or total cholesterol levels consistent with HeFH with examples of these values provided. If the diagnostic pathway is sought through LDL-C thresholds, one of these two criteria must be met (i.e., clinical manifestations or parents of the patient have LDL-C or total cholesterol levels consistent with HeFH). To the criteria that the patient have skeletal-related muscle symptoms resolve upon discontinuation of atorvastatin and rosuvastatin, examples of skeletal-related muscle symptoms (myopathy and myalgia) were added as a Note. 4. Primary Hyperlipidemia. To the criteria that the patient have skeletal-related muscle symptoms resolve upon discontinuation of atorvastatin and rosuvastatin, examples of skeletal-related muscle symptoms (myopathy and myalgia) were added as a Note. 5. Conditions Not Recommended for Approval. The criteria that did not permit Repatha use with Juxtapid were deleted. Concurrent use of Repatha and Praluent is still not allowed. 	04/07/2021

HeFH – Heterozygous familial hypercholesterolemia; LDL-C – Low-density lipoprotein cholesterol; PCSK9 – Proprotein convertase subtilisin kexin type 9; HoFH – Homozygous familial hypercholesterolemia.

APPENDIX A.

Simon Broome Register Diagnostic Criteria.¹⁵

Definite Familial Hypercholesterolemia
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
--Tendon xanthomas in the patient or in a first (parent, sibling, or child) or second-degree relative (grandparent, aunt, or uncle);
OR
DNA-based evidence of LDL-receptor, familial defective APOB, or PCSK9 mutation.
Possible (or Probable) Familial Hypercholesterolemia
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
Family history of premature myocardial infarction younger than 50 years of age in second-degree relative or younger than 60 years of age in first-degree relative;
OR
Raised cholesterol
--Total cholesterol greater than 6.7 mmol/L (260 mg/dL) or LDL-C > 4.0 mmol/L (155 mg/dL) in a child < 16 years; OR
--Total cholesterol > 7.5 mmol/L (290 mg/dL) or LDL-C > 4.9 mmol/L (190 mg/dL) in an adult (aged > 16 years);
AND
Family history of raised cholesterol > 7.5 mmol (290 mg/dL) in adult first-degree or second-degree relative or > 6.7 mmol/L (260 mg/dL) in child or sibling aged < 16 years.

LDL-C – Low-density lipoprotein cholesterol; LDL – Low-density lipoprotein; APOB – Apolipoprotein B; PCSK9 – Proprotein convertase subtilisin kexin type 9.

APPENDIX B.

Dutch Lipid Network Criteria.¹⁶

Criteria	Score
Family History	
First-degree relative with known premature coronary and/or vascular disease (men < 55 years, women < 60 years)	1
First degree relative with known LDL-C > 95 th percentile for age and sex	1
First-degree relative with tendon xanthomata and/or arcus cornealis, OR	2
Children aged < 18 years with LDL-C > 95 th percentile for age and sex	2
Clinical History	
Patient with premature CAD (age as above)	2
Patient with premature cerebral or peripheral vascular disease (age as above)	1
Physical Examination	
Tendon xanthomas	6
Arcus cornealis at age < 45 years	4
LDL-C	
LDL-C ≥ 8.5 mmol/L (330 mg/dL)	8
LDL-C 6.5 to 8.4 mmol/L (250 to 329 mg/dL)	5
LDL-C 5.0 to 6.4 mmol/L (190 to 249 mg/dL)	3
LDL-C 4.0 to 4.9 mmol/L (155 to 189 mg/dL)	1
DNA analysis	
Functional mutation LDLR, APOB or PCSK9 gene	8
Stratification	
Definite familial hypercholesterolemia	> 8
Probable familial hypercholesterolemia	6 to 8
Possible familial hypercholesterolemia	3 to 5
Unlikely familial hypercholesterolemia	< 3

LDL-C – Low-density lipoprotein cholesterol; CAD – Coronary artery disease; LDLR – Low-density lipoprotein receptor; APOB – Apolipoprotein B; PCSK9 – Proprotein convertase subtilisin kexin type 9.

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