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:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Evkeeza, please choose new start of therapy. ☐ new start ☐ continued therapy

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

NOTE: Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting

Is this infusion occurring in a facility affiliated with hospital outpatient setting? Yes ☐ No ☐

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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?
☐ Homozygous Familial Hypercholesterolemia (HoFH)
☐ other (please specify):

Has the patient undergone genetic testing that confirmed two mutant alleles 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 locus? Yes ☐ No ☐
(if no) Does the patient have an untreated (for example, prior to therapy with any antihyperlipidemic agent) low-density lipoprotein cholesterol (LDL-C) level greater than 500 mg/dL? Yes ☐ No ☐
(if yes) Did the patient have clinical manifestations of homozygous familial hypercholesterolemia (for example, cutaneous xanthomas, tendon xanthomas, acrus cornea, tuberous xanthomas, xanthelasma) BEFORE THEY WERE 10 YEARS OLD? Yes ☐ No ☐
(if no) Did the parents of the patient have untreated LDL-C levels or total cholesterol levels consistent with heterozygous familial hypercholesterolemia (for example, an untreated LDL-C level of at least 190 mg/dL and/or an untreated total cholesterol level above 250 mg/dL)? Yes ☐ No ☐
(if no) Was the patient's treated (for example, after therapy with at least one antihyperlipidemic agent) low-density lipoprotein cholesterol (LDL-C) level at least 300 mg/dL? Yes ☐ No ☐
(if yes) Did the patient have clinical manifestations of homozygous familial hypercholesterolemia (for example, cutaneous xanthomas, tendon xanthomas, acrus cornea, tuberous xanthomas, xanthelasma) BEFORE THEY WERE 10 YEARS OLD? Yes ☐ No ☐

(if no) Did the parents of the patient have untreated LDL-C levels or total cholesterol levels consistent with heterozygous familial hypercholesterolemia (for example, an untreated LDL-C level of at least 190 mg/dL and/or an untreated total cholesterol level above 250 mg/dL)? Yes ☐ No ☐

Has the patient had a documented trial of one high-intensity statin therapy (for example, atorvastatin 40 mg daily or higher; rosuvastatin tablets 20 mg daily or higher [as a single-entity or as a combination product])? Yes ☐ No ☐
(if yes) Has the patient had a documented trial of 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 (LDL-C) level after this treatment regimen remain 70 mg/dL or higher? Yes ☐ No ☐
(if no) Has the patient experienced statin-related rhabdomyolysis? Yes ☐ No ☐
(if no) Has the patient experienced skeletal-related muscle symptoms (for example, myopathy [muscle weakness] or myalgia [muscle aches, soreness, stiffness, or tenderness])? Yes ☐ No ☐
(if yes) Has the patient had skeletal-related muscle symptoms that occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products)? Yes ☐ No ☐
(if yes) When the patient was receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products) did the skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin)? Yes ☐ No ☐

Has the patient undergone genetic testing and found to have have two LDL-receptor negative alleles? Yes ☐ No ☐
(if no) Has the patient had a documented trial of, or is not a candidate for, a proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitor for at least 8 continuous weeks (for example, Repatha)? Yes ☐ No ☐
(if yes) Has the patient's low-density lipoprotein cholesterol (LDL-C) level after this PCSK9 inhibitor therapy remained at 70 mg/dL or higher? Yes ☐ No ☐

Is Evkeeza being 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? Yes ☐ No ☐

Additional pertinent information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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