UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Evkeeza (evinacumab)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met):

1. Is the patient at least 5 years of age? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH) ? ❑ **Yes** ❑ **No**
3. Is the patient currently treated with other background HoFH therapy **AND** is unable to reach their LDL-C goal at maximum tolerated doses of medication background therapy for HoFH? ❑ **Yes** ❑ **No**
    a. LDL-C Goal: _____
    b. LDL-C level while on background therapy: _____
    c. Background therapy (medication name and dose): _____
    d. Details of Failure: _____
4. Is Evkeeza being used as an **ADJUNCT** to a maximally tolerated dose/intensity statin therapy, ezetimibe, or PCSK9 unless contraindicated or serious adverse events for HoFH? ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient had clinically significant improvement as shown by the specific appropriate monitoring parameters and/or improvement in symptoms? ❑ **Yes** ❑ **No**
    ☐ LDL-C is now at goal; **OR**
    ☐ Patient has had at least a 30% reduction of LDL-C from baseline

2. Does the patient continue to receive concomitant lipid-lowering therapy at the maximally tolerated dose or have an intolerance or contraindication to other lipid lowering therapies? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date