Premier Health Plan

POLICY AND PROCEDURE

POLICY TITLE: ***Repatha® (Evolocumab)***
DEPARTMENT: **Clinical Pharmacy Services – Utilization Management**
ORIGINAL DATE: ***July 2015 (as adopted from UPMC Health Plan)***

Last P & T Committee Approval Date: *September 2018*

Product Applicability: *mark all applicable products below:*

COMMERCIAL	[ ] HMO [ ] PPO *Products*: [ ] Small [ ] Indiv. [ ] Large *Exchange*: [ ] Shop [ ] Indiv. [x] All
OTHER	[x] Self-funded/ASO

PURPOSE

The purpose of this policy is to define the prior authorization process for Repatha® (evolocumab).

Repatha® (evolocumab) is indicated as:

- Adjunct to diet and other LDL-lowering therapies for the treatment of patients with Homozygous Familial Hypercholesterolemia (HoFH)
- To reduce the risk of myocardial infarction, strokes, and coronary revascularizations in adults with established cardiovascular disease
- Adjunct to diet for treatment alone or in combination with other lipid-lowering therapies for treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce low-density LDL-C

DEFINITIONS

Acute Coronary Syndrome (ACS) – a spectrum of conditions with acute myocardial ischemia and/or infarction that are usually due to an abrupt reduction in coronary blood flow, including ST-elevation myocardial infarction (STEMI), non-STEMI (NSTEMI), and unstable angina (UA)

ASCVD – atherosclerotic cardiovascular disease

ACC/AHA – American College of Cardiology/American Heart Association

Arcus Cornealis – white deposit of lipids in the outer rim of the iris due to high LDL-C levels

Clinical ASCVD – acute coronary syndromes, a history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin

Dutch Lipid Clinic Network/WHO Criteria for Familial Hypercholesterolemia – scoring system developed to calculate a numeric score that predicts the probability of the diagnosis of familial hypercholesterolemia (FH). Diagnosis of FH is certain when the score is >8, probable when the score is 6-8, and possible when the score is 3-6.

Heterozygous FH (HeFH) – a common genetic cause of premature coronary heart disease due to lifelong elevated LDL-C

High Intensity Statin – daily dose lowers LDL-C by approximately ≥ 50%

Moderate Intensity Statin – daily dose lowers LDL-C by approximately 30% to < 50%

Tendon Xanthoma – cholesterol deposit formation on the Achilles tendon and/or extensor tendons of hands and feet, or on the knees and elbows, caused by increased LDL-C levels

Statin Intensity (Per 2013 ACC/AHA Guidelines)

High-intensity Statin (lowers cholesterol by ≥ 50%)	Moderate-intensity Statin (lowers cholesterol by 30-50%)	Low-intensity Statin (lowers cholesterol by <30%)
• Atorvastatin 40-80 mg a day • Rosuvastatin 20-40mg a day	• Atorvastatin 10-20 mg a day • Rosuvastatin 5-10 mg a day • Simvastatin 20-40 mg a day • Pravastatin 40-80 mg a day • Lovastatin 40mg a day • Fluvastatin XL 80mg a day • Fluvastatin 40mg twice a day • Pitavastatin 2-4mg a day	• Simvastatin 10 mg a day • Pravastatin 10-20 mg a day • Lovastatin 20 mg a day • Fluvastatin 20-40 mg a day • Pitavastatin 1 mg a day

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity, and approval by the Pharmacy & Therapeutics Committee of the criteria for prior authorization, as described in RX.002 Pharmacy and Therapeutics Committee and RX.003-Prior Authorization Process.

The drug Repatha® (evolocumab) is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all of the criteria listed below:

- Must be prescribed by or in consultation with a cardiologist, clinical lipidologist, or endocrinologist
- Must be age 18 years or older
    - Exceptions will be made for members age 13 years or older using Repatha for HoFH
- Must provide chart documentation indicating that the member has been counseled on the benefits of therapeutic lifestyle changes (i.e. diet, exercise, weight management, smoking cessation)
- Must have ONE of the following diagnoses:
    - Clinical atherosclerotic cardiovascular disease (ASCVD) – Chart documentation confirming the history of at least ONE of the following is required:
        - Myocardial infarction (MI) or other acute coronary syndromes (ACS) [e.g., ST-elevation myocardial infarction (STEMI), non-ST-elevation myocardial infarction (NSTEMI), unstable angina (UA)]
        - Coronary or other revascularization procedure
        - Ischemic stroke or transient ischemic attack (TIA)
        - Atherosclerotic peripheral arterial disease (includes ankle/brachial index of <0.90)
        - Coronary artery calcium (CAC) ≥300 Agatston units or ≥75th percentile for age, sex, and ethnicity.
            - CAC reference values can be found at: http://www.mesa-nhlbi.org/CACReference.aspx
        - Carotid plaque ≥50%
        - Coronary atherosclerosis as demonstrated by angiography (cardiac CT angiography or conventional cardiac catheterization)

- Other documented atherosclerotic vascular disease will be considered on a case-by-case basis

- Heterozygous familial hypercholesterolemia (HeFH) – chat documentation must be provided showing at least ONE of the following to support the diagnosis:
  - Simon Broome criteria for definite familial hypercholesterolemia, as defined by meeting BOTH of the following:
    - Must have Total Cholesterol (TC) >290mg/dL OR LDL-C >190mg/dL
    - Tendon xanthomas must be present in patient or patient's parent, child, grandparent, sibling, uncle, or aunt
  - Dutch Lipid Clinic Network/WHO criteria for probable familial hypercholesterolemia with a diagnostic score of 6 or greater based on the scoring chart below

	Clinical Signs	Score
Family History	First degree relative known with premature (men < 55 years; women < 60 years) coronary and vascular diseases	1
	First degree relative known with LDL-cholesterol >95th percentile	1
	First degree relative with tendon xanthomas and/or arcus cornealis	2
	Children below 18 years with LDL-C >95th percentile	2
Clinical History	Patient has premature (men < 55 years; women < 60 years) CAD	2
	Patient has premature (men < 55 years; women < 60 years) cerebral or peripheral vascular disease	1
Physical Examination	Tendon xanthomas	6
	Arcus cornealis below the age of 45 years	4
Laboratory Analysis	LDL-C > 330 mg/dL (8.5 mmol/L)	8
	LDL-C = 250-329 mg/dL (6.5-8.4 mmol/L)	5
	LDL-C = 190-249 mg/dL (5.0-6.4 mmol/L)	3
	LDL-C = 155-189 mg/dL (4.0-4.9 mmol/L)	1
DNA Analysis	Functional mutation LDL receptor gene present	8

- Homozygous familial hypercholesterolemia (HoFH) - the diagnosis must either be confirmed by genetic testing or a clinical diagnosis defined as ONE of the four following scenarios:
  - Must have documented functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality
  - Must have untreated LDL-C level >500mg/dL, total cholesterol (TC) > 500mg/dL, and triglycerides (TG) <300mg/dL **and** have both parents with untreated TC >250mg/dL

        - Must have untreated TC >500mg/dL and TG <300mg/dL **and** have both parents with untreated TC >250 mg/dL **and** ONE of the following:
            - Skin fibroblast LDL receptor activity <20% normal
            - Presence of cutaneous and tendon xanthomas and corneal arcus in the first decade of life
        - Must have untreated LDL-C level > 500mg/dL and ONE of the following:
            - Skin fibroblast LDL receptor activity <20% normal
            - Presence of cutaneous and tendon xanthomas and corneal arcus in the first decade of life
- Must submit baseline (within one month) lipid panel including LDL-C level demonstrating uncontrolled LDL-C beyond recommended goals
- Must submit target LDL-C goals
- Must be on concurrent therapy with a maximally tolerated dose of a HMG-CoA Reductase Inhibitor (statin) unless statin intolerant
- Must have an adequate trial of the two high intensity statins (rosuvastatin 20-40mg daily and atorvastatin 40-80mg daily) for at least 2 continuous months each with demonstrated adherence (based on pharmacy claims and/or chart documentation)
    - Only 1 high intensity statin trial is required for members who have been adherent to a maximally tolerated dose of a high intensity statin for at least 2 continuous months and still require a >20% decrease in LDL-C to achieve their target level
    - For members who are currently taking a maximally tolerated dose of a high intensity statin, and a ≤20% decrease in LDL-C is required to achieve target level, the member must also try ezetimibe combined with a statin at maximally tolerated dose for at least 4 continuous weeks with demonstrated adherence to both the statin and ezetimibe
    - If the member has not tried 2 high intensity statins with/without ezetimibe due to intolerance, the following is required:
        - Must try at least 3 statins. Documentation must be provided to confirm that all prior statin trial(s) were started at the lowest daily starting dose, and that a dose reduction (reduction in daily dose or dosing frequency) was attempted to resolve adverse effects during these trials.
        - When a ≤20% decrease in LDL-C is required to achieve target levels, the member must try ezetimibe, or other cholesterol medications (such as fibrates or bile acid sequestrants) either alone

or in combination with a statin (if tolerated) for at least 4 continuous weeks with demonstrated adherence

- If the member cannot use statins due to a contraindication, the following documentation is required:
  - The member must have documented active liver disease, which may include unexplained persistent elevations in hepatic transaminase levels
  - Trial of ezetimibe or other cholesterol lowering medications (fibrates, bile acid sequestrants) for at least 2 continuous months with demonstrated adherence if a ≤ 20% decrease in LDL-C is required to achieve target levels

Reauthorization Criteria:

All prior authorization renewals are reviewed on an annual basis to determine the Medical Necessity for continuation of therapy. Authorization may be extended at 1-year intervals based upon the following:

- Documentation of recent lipid panel (within last 3 months) indicating reduction in LDL-C with therapy
- Chart documentation/claims data demonstrating patient is continuing treatment with the maximally tolerated dose of a statin (when applicable)
- Pharmacy claims and/or chart documentation must demonstrate adherence to treatment recommendations (medication and lifestyle changes)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 3 months
Reauthorization	Up to 1 year
Quantity Level Limit	
Repatha 140mg/mL	2 pens/syringes per 28 days
Repatha 420mg/3.5 mL Pushtronex	1 cartridge per 28 days

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Repatha [prescribing information]. Thousand Oaks, CA: Amgen Inc; December 2017.
2. Stone NJ, Robinson JG, 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. J Am Coll Cardiol. 2014;63(25_PA):. doi:10.1016/j.jacc.2013.11.002.
3. Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults. Executive summary of the third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA. 2001;285:2486-2497.
4. Raal FJ, Santos RD. Homozygous familial hypercholesterolemia: current perspectives on diagnosis and treatment. Atherosclerosis 2012; 223: 262–68.
5. Scientific Steering Committee on behalf of the Simon Broome Register Group. Risk of fatal coronary heart disease in familial hypercholesterolemia. Br Med J 1991;303:893-6.
6. World Health Organization. Familial hypercholesterolemia. Report of a second WHO consultation. Geneva: World Health Organization; 1999.
7. Watts GF, Gidding S, Weirzbicki AS, et al. Integrated guidance on the care of familial hypercholesterolaemia from the International FH Foundation. Int J Cardiol 2014;171:309-325.
8. Jacobson TA, Ito MK, Maki KC, et al. National Lipid Association recommendations for patientcentered management of dyslipidemia: part 1 – full report. J Clin Lipidol 2014;8:473-488.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Criteria update	*01/16, 01/18*
Annual review	*02/16, 02/17, 02/18*
Removed Praluent from Policy	*09/18*