Evkeeza (Evinacumab)

EXCEPTION DRUG STATUS (EDS) REQUEST FORM

Fax: (204) 942-2030 or 1-877-208-3588

Prescriber Name:	**Fax Number:**
Prescriber Address:	**Phone Number:**
	Prescriber License Number (NOT Billing Number):

Patient First Name:	**PHIN:**	**MHSC:**
Patient Last Name:	**Patient's Date of Birth:**	
◯ **Initial Request**	◯ **Renewal Request**	
Strength, Dosage Form and Regimen:	**Expected Duration of Therapy:**	

Exception Drug Status (EDS) approval is only granted upon demonstration that the patient meets the coverage criteria of the EDS listing. Please provide the following details about how this patient meets the specific criteria for coverage. Manitoba Health may request additional documentation to support this EDS request.

For INITIAL Requests:

PART 1: Diagnosis/Indication

Diagnosis/Indication:	◯ **Homozygous Familial Hypercholesterolemia (HoFH)**		
	◯ Other:		
Please select YES or NO to the following:			
Patient is 5 years of age or older.		◯ YES	◯ NO
If CLINICALLY confirmed diagnosis of HoFH: Patient has untreated total cholesterol (TC) >12.93 mmol/L and triglycerides (TG) <3.39 mmoL/L **Untreated TC level: _____ mmol/L Date: _____** **Untreated TG level: _____ mmol/L Date: _____**		◯ YES	◯ NO
AND Both parents have documented TC >6.47 mmol/L, indicative of heterozygous familial hypercholesterolemia (HeFH);		◯ YES	◯ NO
OR Patient has a history of cutaneous or tendinous xanthoma before 10 years of age.		◯ YES	◯ NO
If GENETICALLY confirmed diagnosis of HoFH (*please provide a copy of the genetic report):* Patient has documented functional mutation(s) in both low density lipoprotein receptor (LDLR) alleles;		◯ YES	◯ NO
OR Patient has documented homozygous or compound heterozygous mutations in apolipoprotein B (ApoB) or proprotein convertase subtilisin/kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1), or at least 2 such variants at different loci.		◯ YES	◯ NO

PART 2: Lab Results (Low Density Lipoprotein Cholesterol [LDL-C])

LDL-C level AFTER an adequate trial of all other accessible lipid-lowering therapies for at least 3 months and PRIOR to initiation of Evinacumab:

LDL-C level: _____ mmol/L Date of result: _____

PART 3: Medication History

Please provide the following information:

Name of Drug	*Dosing Regimen*	*Start Date*	*End Date (if applicable)*	*Outcome of Treatment*
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):
				☐ Ineffective ☐ Intolerance (specify): ☐ Contraindication (specify): ☐ Other (specify):

Will Evinacumab be used as an adjunct to diet and other LDL-C lowering therapies?	◯ YES	◯ NO
Is Evinacumab being prescribed by, or in consultation with, a specialist with expertise in the diagnosis and management of HoFH (e.g., [pediatric] endocrinologist, cardiologist, lipidologist)?	◯ YES	◯ NO

Additional Relevant Clinical Information:

For ALL RENEWAL Requests:

Please provide proof of beneficial clinical effect, defined as a reduction in LDL-C from baseline that is considered clinically beneficial for the patient.

LDLC level: _____ mmol/L Date of Result: _____

Additional Relevant Clinical Information:

Prescriber Signature and Date:

☐ **I have discussed with the patient that the purpose of releasing their information to Manitoba Health, Seniors and Long-Term Care is to obtain Exception Drug Status for prescription coverage.**

Date:	Prescriber Signature: