

# UNDERSTANDING THE — SUMMARY — OF BENEFITS

FOR EVKEEZA<sup>®</sup> (evinacumab-dgnb)

## > Detailed information about your patient's health insurance coverage for EVKEEZA

- Once you prescribe EVKEEZA for your patient, **a benefits investigation** is an important first step to determining how EVKEEZA will be covered under your patient's health insurance plan
- When you choose the myRARE<sup>TM</sup> Patient Support Program (PSP) for EVKEEZA for **access and reimbursement support services**:
  - myRARE conducts a benefits investigation on behalf of your patient
  - myRARE sends you a summary of benefits that outlines the patient's coverage for EVKEEZA and provides important information needed to access EVKEEZA
- This resource previews what is included in the summary of benefits and **identifies information that will be required** to access EVKEEZA once you prescribe it for your patient. The summary of benefits is not a guarantee of insurance coverage and all benefits are subject to the terms of the insured's plan at the time services are rendered
- Benefits will be verified **based on preferences** indicated on the Start Form. If preference is not covered by the patient's plan, alternative options will be investigated and coverage information provided on the Summary of Benefits

>

Preferred Treatment Setting	Preferred Acquisition Channel
<input type="checkbox"/> Home	Specialty pharmacy with home infusion
<input type="checkbox"/> Clinical setting <div style="display: flex; justify-content: space-between; padding: 0 10px;"> <span><input type="checkbox"/> In-office</span> <span><input type="checkbox"/> Infusion center</span> </div>	<input type="checkbox"/> Buy and bill <input type="checkbox"/> Specialty pharmacy to bill
<input type="checkbox"/> Undecided—Benefits information will be provided for available options based on plan coverage	



## > Summary of benefits: Patient benefit profile


Note: A benefits investigation is not a guarantee of insurance coverage. All benefits are subject to the insured's plan at the time services are rendered. Under no circumstances shall the myRARE<sup>TM</sup> Patient Support Program be held responsible or liable for payment of any claims, benefits, or cost. Any coding information discussed in this document is provided for informational purposes only, is subject to change, and should not be construed as legal advice. Providers should exercise independent clinical judgment when selecting codes and submitting claims to accurately reflect the services and products furnished to the specific patient.

### Page 2 preview

The first section of the patient benefit profile includes:

- A** The **ID number assigned to your patient** by the myRARE PSP. Refer to the patient ID when speaking with a program representative
- B** A summary of your patient's **health insurance information**
- C** The **diagnosis code** for treatment with EVKEEZA

Patient ID: [Record ID#]  
Health Plan: [Health Plan Name]  
Coverage: [Primary | Secondary | Tertiary]



**Summary of Benefits for EVKEEZA® (evinacumab-dgnb)**  
Patient benefit profile

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**A** Patient ID: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_

Plan name: \_\_\_\_\_

Group number: \_\_\_\_\_

Policy effective date: \_\_\_\_\_

Policy effective: ☐ Plan year dates: \_\_\_\_\_ ☐ Calendar year (January 1-December 31)

Verified for primary diagnosis: \_\_\_\_\_

Verified tertiary diagnosis: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Payer name: \_\_\_\_\_

Plan type: \_\_\_\_\_ Policy number: ( ) \_\_\_\_\_

Policy level: \_\_\_\_\_ ☐ Primary ☐ Secondary ☐ Tertiary

Policy end date: \_\_\_\_\_


Payer phone: ( ) \_\_\_\_\_ Payer contact: \_\_\_\_\_ Self funded: ☐ Yes ☐ No

Verified for secondary diagnosis: \_\_\_\_\_

Continued on next page.

**REGENERON**

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**Evkeeza**<sup>®</sup>  
(evinacumab-dgnb)



## > Summary of benefits: Patient benefit profile (cont'd)

### Page 4-5 preview

Page 4 includes the following infusion and PA information:

**G** Does the health plan **cover or not cover the infusion administration** (in-office or at home) for EVKEEZA

Your patient's **financial responsibility** for the infusion, such as applicable copays and deductibles, and other potential out-of-pocket expenses and benefit information

**G1** In-office coverage and cost

**G2** Home infusion coverage and cost

**H** If a **PA is required**, this section lists the criteria and documentation for filing a PA, and contact information and instructions for submitting a PA

**I** Page 5 captures **any additional instructions or notes from the health plan** that may guide your practice in submitting documentation for your patient's treatment with EVKEEZA

**G**

Patient ID: [Record ID#]  
Health Plan: [Health Plan Name]  
Coverage: [Primary] [Secondary] [Tertiary]

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Infusion administration benefit	
Outcome	<input type="checkbox"/> Covered- if authorized <input type="checkbox"/> Covered- no authorization required <input type="checkbox"/> Not covered
Deductible	Enter amount: \$
Deductible met	Enter amount: \$
Out-of-pocket maximum	Enter amount: \$ <input type="checkbox"/> Includes deductible <input type="checkbox"/> Excludes deductible
Out-of-pocket maximum met	Enter amount: \$
Lifetime maximum	Enter amount: \$
Additional benefit information	

Home infusion administration	
Outcome	<input type="checkbox"/> Covered- if authorized <input type="checkbox"/> Covered- no authorization required <input type="checkbox"/> Not covered
Deductible	Enter Amount: \$
Deductible met	Enter Amount: \$
Out-of-pocket maximum	Enter Amount: \$ <input type="checkbox"/> Includes deductible <input type="checkbox"/> Excludes deductible
Out-of-pocket maximum met	Enter Amount: \$
Lifetime maximum	Enter Amount: \$
Additional benefit information	

Prior authorization requirements				
	Infusion administration benefit	Physician purchase option through major medical benefits	Specialty pharmacy option through major medical benefit	Specialty pharmacy option through prescription drug benefit
Prior authorization/Pre-determination required				
Required documentation	---			
Required criteria	---			
To the attention of	---			
Phone	---			
Fax	---			
PA status	---			
PA expiration date	---			
PA instructions	---			

PAGE 4

**I**

Patient ID: [Record ID#]  
Health Plan: [Health Plan Name]  
Coverage: [Primary] [Secondary] [Tertiary]

Record any special instructions or additional notes within the space below.

[Claims addresses, billing guidelines, benefit summary/additional info (coordination of benefits)]

If you have any questions about this letter or myRARE<sup>TM</sup>, please contact myRARE at 1-833-4my-RARE (1-833-469-7273) Option 1, Monday-Friday, 9 AM-9 PM Eastern time.

Sincerely,

Signature:  
Site Coordinator First Name | Site Coordinator Last Name |  
myRARE Coordinator

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