Welcome to the LEQVIO® Service Center

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

We're here to assist you with getting LEQVIO for your patients

At the LEQVIO Service Center, we provide access and reimbursement support to your patients who have been prescribed LEQVIO.

HOW DO I GET STARTED?

Complete our simple, one-page Start Form. Use a paper copy or print an editable PDF from LEQVIO-access.com and fax it to **877-537-8468**

It's important to include all information marked (REQUIRED) on the next page to ensure complete enrollment.

WHAT HAPPENS NEXT?

Get Dedicated Support – Your Access Specialist will check the patient's insurance coverage, including available options to acquire the product, identify prior authorization requirements, and assess eligibility for financial assistance

Order LEQVIO – Ensure your practice establishes an account with an authorized distributor before ordering and prepare for inventory storage needs

Schedule the Patient's Appointment and Administer LEQVIO – For dosing and administration information, please visit LEQVIOhcp.com

Submit Claim – Use J-code J1306 along with the JZ modifier when submitting a claim for reimbursement[1,2]

References: 1. Centers for Medicare & Medicaid Services. CMS HCPCS Application Summaries and Coding Recommendations: First Quarter, 2022 HCPCS Coding Cycle. Accessed July 11, 2023. https://www.cms.gov/files/document/2022-hcpcs-application-summary-quarter-1-2022-drugs-and-biologicals.pdf **2.** Centers for Medicare & Medicaid Services. Medicare program: discarded drugs and biologicals–JW modifier and JZ modifier policy frequently asked questions. Accessed May 17, 2023. https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

NOVARTIS

LEQVIO® Service Center Start Form

Phone: 833-LEQVIO2 **Fax:** 877-537-8468 (877-LEQVIO8) **Service Center Portal:** ServiceCenterPortal.com

☐ **Full-service support**
Choosing full-service support will provide the following services:
- Novartis Access & Reimbursement Expert support
- Insurance Determination & Coverage Review (includes Benefits Verification, Prior Authorization/Appeals research)
- Patient affordability support

OR

☐ **Novartis Access & Reimbursement Expert support only**
- This option allows Novartis Access & Reimbursement Expert visibility to patient-level information to assist with patient access for providers who self-manage insurance and coverage determination review or refer to an alternate site of care for treatment

PATIENT INFORMATION

* = REQUIRED FIELDS

* First Name: ______ * Last Name: ______ Email: ______

Sex: ☐ Male ☐ Female * Date of Birth: ______ Home Phone: ______ Cell Phone: ______

OK to leave voicemail on: ☐ Home Phone ☐ Cell Phone Preferred Language: ☐ English ☐ Spanish Other: ______

* Address: ______ City: ______ State: ______ ZIP Code: ______

PATIENT AUTHORIZATION & ADDITIONAL CONSENTS (patients may visit www.servicecenter.ehipaa.com to complete their information as well)

Information sharing and enrollment:
- May share information when working with my health care plan to understand coverage for LEQVIO, and for purposes stated in the Authorization section on page 3
- Novartis does not and will not sell or rent your information to marketing companies or mailing list brokers
- Novartis program enrollment is voluntary and always provides patients with an easy option to cancel participation

I have read and agree to the Patient Authorization on page 3.

* ______ Patient/Legal Guardian Signature ____/____/______ Date of Signature (MM/DD/YYYY)

LEQVIO Co-pay Program

☐ I have read and agree to the Co-pay Program Terms & Conditions on page 3.

Ongoing Support from the LEQVIO Care Program

☐ Enroll in dedicated phone support from LEQVIO Care—an optional program to help me stay on track with my treatment plan, and receive medication reminders, healthy living tips, and tools. By checking the box, I agree to receive calls and texts at the phone number provided.*

Foundation Assistance

If you are experiencing financial hardship, cannot afford the cost of your treatment, and have limited or no prescription coverage, then you may be eligible to receive Novartis medications for free through the Novartis Patient Assistance Foundation, Inc. (NPAF). The Service Center can connect you with NPAF to determine eligibility.

* **INSURANCE INFORMATION: Front and back copies of all patient insurance cards: primary, secondary (if applicable), and prescription**

Select all that apply: ☐ Primary ☐ Secondary ☐ Prescription/Pharmacy

PROVIDER INFORMATION

* Provider Name: ______ Practice Name: ______

* Practice NPI #: ______ Provider NPI #: ______ Tax ID #: ______

Primary Office Contact: ______ Office Contact Phone: ______ Ext: ______ Office Fax: ______

Address: ______ City: ______ State: ______ * ZIP Code: ______ Office Phone: ______

How will the product be acquired?

☐ Provider purchase (buy-and-bill under the medical benefit) ☐ Specialty pharmacy (through medical or pharmacy benefit)

☐ I plan to send my patient to an alternate site of care to receive LEQVIO (TREATING SITE information required below)

TREATING SITE: If you intend to send your patient to an alternate site of care to receive LEQVIO, please complete the information below. You may also visit our locator tool at LEQVIO-locator.com to find a site.

Send updates and communications to: ☐ Referring physician/site ☐ Treating site

Site Name: ______ Contact Name: ______ Phone: ______

Fax: ______ Email: ______ NPI #: ______ Tax ID #: ______

CLINICAL INFORMATION

* **1. Primary diagnosis section (must select one; complete ICD-10-CM to highest level of specificity) - REQUIRED**

I confirm the patient has been currently receiving statin therapy (or has been determined clinically intolerant) and has been diagnosed with:

☐ **E78.______ Hyperlipidemia** (E78.00, E78.2, E78.4, E78.49, E78.5)

OR

☐ **E78.01 Familial hypercholesterolemia (eg, HeFH)**
- ☐ Z83.42 Family history of familial hypercholesterolemia
- ☐ E75.5 Other lipid storage disorders (approximate synonyms include tendon xanthoma)
- ☐ Other (specify ICD-10-CM): ______

(supporting documents include Simon Broome diagnostic, Dutch Lipid Clinic score, and/or genetic testing)

OR

☐ **Other (specify ICD-10-CM):** ______

2. Secondary diagnosis(es) (please complete if Hyperlipidemia above is selected; complete ICD-10-CM to highest level of specificity) - RECOMMENDED

☐ **Clinical ASCVD:**
- ☐ I2___.______ Ischemic heart disease
- ☐ I6___.______ Cerebrovascular disease
- ☐ I70.______ Atherosclerosis
- ☐ I73.______ Other peripheral vascular disease
- ☐ Other (specify ICD-10-CM): ______

AND/OR

☐ **Other clinical risk factors:**
- ☐ E11.______ Diabetes mellitus
- ☐ I10.______ Hypertension
- ☐ Other (specify ICD-10-CM): ______

3. LDL-C level:

Current level: ______ Date taken: ______ (MM/DD/YYYY) Current LDL-C lowering treatment(s): ______

☐ Patient was previously enrolled in an inclisiran clinical trial. Last inclisiran injection date: ______

* **PRESCRIBER CERTIFICATION** ☐ I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed LEQVIO to the previously identified patient or a physician's designee, and that I provided the patient with a description of the LEQVIO Service Center. I agree to the NPAF Authorization on page 3. I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the LEQVIO Service Center.

* ____/____/______ Date (MM/DD/YYYY)

Can we contact the patient if they have issues with enrollment? ☐ Yes, and I certify that I have obtained HIPAA authorization from the patient to disclose the information on this form to Novartis Pharmaceuticals Corporation, its affiliates and service providers (NPC) to facilitate enrollment in this program, including contacting the patient.

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Patient Authorization. I authorize my health care providers, pharmacies and health insurers, and their service providers ("Providers") to disclose information relating to my insurance benefits, medical condition, treatment and prescription details ("Personal Information") to Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis") and the Novartis Patient Assistance Foundation, Inc., and its service providers ("NPAF") so they can provide the following support services (the "Services"):

- Help coordinate insurance coverage for, access to, and receipt of my medication.
- Communicate with me about possible financial assistance, including Novartis co-pay or NPAF programs, and, if I am enrolled, administer my participation in those programs.
- Communicate with me about my medication and treatment, including reminders, health and lifestyle tips, and product and other related information.
- Communications may be customized based on Personal Information obtained from my Providers.
- Conduct quality assurance and other internal business activities and ask for feedback related to the Services or my treatment.

In delivering the Services, Novartis and NPAF may share my Personal Information with each other, with my Providers, or with government agencies or other financial assistance programs that might help me pay for my medication. They may combine information collected from me with information collected from other sources and use that information to administer the Services. My pharmacies or other health care providers may receive payment from Novartis or NPAF for providing certain Services, such as medication or refill reminders, based on my enrollment or participation. Once I authorize disclosure of my Personal Information, it may no longer be protected by federal health privacy law and applicable state laws.

I understand I do not have to sign this Authorization to get my medication or insurance coverage, that I have a right to a copy, and can cancel this Authorization at any time by calling 833-LEQVIO2 or writing to:

CareMetx 610 Crescent Executive Court, Suite 200 Lake Mary, FL 32746	OR	Customer Interaction Center Novartis Pharmaceuticals Corporation One Health Plaza East Hanover, NJ 07936-1080

This Authorization will expire 5 years after I sign it, or earlier if required by state law, unless I cancel it sooner. If I cancel it, I may no longer qualify for Services from Novartis or NPAF, but it will not impact my Provider's treatment or my insurance benefits. I also understand that if a Provider is disclosing my Personal Information to Novartis or NPAF on an authorized, ongoing basis, my cancellation will be effective with respect to that Provider as soon as they receive notice of my cancellation. Cancellation will not affect prior uses or disclosures.

Co-pay Program Terms and Conditions

Limitations apply. Valid only for those with commercial insurance. The Program may include the Co-pay Card, Payment Card (if applicable), and Rebate, with a per treatment benefit maximum of $3,000 and an annual benefit limit of $3,600. For patients covered under the medical benefit, rebate for out-of-pocket costs will be assigned directly to provider, unless patient requests direct reimbursement. Patient is responsible for any costs once limit is reached in a calendar year. Program not valid (i) under Medicare, Medicaid, TRICARE, VA, DoD, or any other federal or state health care program, (ii) where patient is not using insurance coverage at all, (iii) where the patient's insurance plan reimburses for the entire cost of the drug, or (iv) where product is not covered by patient's insurance. The value of this program is exclusively for the benefit of patients and is intended to be credited towards patient out-of-pocket obligations and maximums, including applicable co-payments, coinsurance, and deductibles. Program is not valid where prohibited by law. Patient may not seek reimbursement for the value received from this program from other parties, including any health insurance program or plan, flexible spending account, or health care savings account. Patient is responsible for complying with any applicable limitations and requirements of their health plan related to the use of the Program. Valid only in the United States and Puerto Rico. This Program is not health insurance. Program may not be combined with any third-party rebate, coupon, or offer. Proof of purchase may be required. Novartis reserves the right to rescind, revoke, or amend the Program and discontinue support at any time without notice.

Novartis Patient Assistance Foundation (NPAF) Authorization FOR PHYSICIAN

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed the drug identified above to the previously identified patient. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

*The LEQVIO Service Center may call and text you at the numbers provided for non-marketing purposes (e.g., to help you access and start on LEQVIO). Calls may be autodialed or prerecorded. Message and data rates may apply. You may change your communication preferences at any time by calling 833-LEQVIO2.

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