LEQVIO® Service Center Start Form

LEQVIO (inclisiran) injection 284 mg/1.5 mL

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

1 **Please ensure Sections 2-8 and 10 are completed** for insurance coverage review and patient affordability support.

☐ **OPTIONAL: Check this box and complete Section 9** to have the Service Center initiate the transfer to the alternate treating site by forwarding this Start Form and results of the coverage review.

Note: The LEQVIO Service Center is not affiliated with the treating site. Selecting this option does not guarantee that your order is complete. The Service Center does not follow up with the site on your behalf; you remain solely responsible for communicating directly with the treating site.

* = REQUIRED FIELDS

PATIENT SECTION

2 **PATIENT INFORMATION**

* First Name: _____ * Last Name: _____ * Date of Birth: _____

Sex: ☐ Male ☐ Female Email: _____ * Phone Number: _____ ☐ Home ☐ Mobile

Preferred Language: ☐ English ☐ Spanish OK to leave voicemail: ☐ Yes ☐ No

* Address: _____ * City: _____ * State: _____ * ZIP Code: _____

3 * **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 ☐ Patient is uninsured

4 * **PATIENT AUTHORIZATION & ADDITIONAL CONSENTS** (Patients may visit servicecenter.ehipaa.com to complete their information as well)

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 the LEQVIO Care Program—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.*

5 **PRESCRIBER INFORMATION** (If you use the Service Center Portal, please fill in the Practice NPI using the number you are registered with)

* Prescriber Name: _____ * Prescriber NPI: _____ Tax ID: _____

Practice Name: _____ Practice NPI: _____

* Address: _____ * City: _____ * State: _____ * ZIP Code: _____

* Office Phone: _____ * Office Fax: _____

Primary Office Contact: _____ Office Contact Phone: _____ Ext: _____

6 * **PRIMARY DIAGNOSIS** (Select one; complete ICD-10-CM to the highest level of specificity)

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

Hyperlipidemia: ☐ E78.00 ☐ E78.2 ☐ E78.4 ☐ E78.5 **Familial hypercholesterolemia (eg, HeFH):** ☐ E78.01 ☐ Z83.42 ☐ E75.5

Other: ☐ _____

7 **TREATING SITE LOCATION** (Specify the location where service will be rendered. Refer to CMS guidelines regarding Place of Service Code for professional claims)

Select where the patient will receive LEQVIO: ☐ 11 - Office ☐ 22 - On Campus — Outpatient Hospital ☐ Other (specify) _____

8 **ALTERNATE TREATING SITE** (REQUIRED only if sending patient to an alternate treating site to receive LEQVIO. Visit LEQVIO-locator.com to find a site.)

Site name: _____ NPI: _____ Tax ID: _____

Site address: _____ City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

9 **LEQVIO ORDER INFORMATION** (REQUIRED only if requesting transfer from the LEQVIO Service Center to an alternate treating site)

Valid for 1 year from provider signature date (select all that apply)

Initial dose: ☐ LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous initially, then LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous in 3 months

Maintenance dose: ☐ LEQVIO (inclisiran) 284 mg/1.5 mL subcutaneous every 6 months

Continuing therapy - last treatment date: (MM/DD/YYYY): _____

10 **PRESCRIBER ATTESTATION** I certify the above therapy is medically necessary and this information is accurate to the best of my knowledge. I certify I am the provider who has prescribed LEQVIO to the patient named on this form. I certify that any medication received from Novartis Pharmaceuticals Corporation, its affiliates and service providers ("Novartis"), or the Novartis Patient Assistance Foundation, Inc. and its service providers ("NPAF"), will be used only for the patient named on this form and will not be offered for sale, trade, or barter, returned for credit, or submitted for reimbursement in any form. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that Novartis and NPAF may revise, change, or terminate their respective programs at any time. **I have discussed the LEQVIO Service Center with my patient, who has authorized me under HIPAA and state law to disclose their information to Novartis for the limited purpose of enrolling in the LEQVIO Service Center. To complete this enrollment, Novartis may contact the patient by phone, text, and email.**

* _____ * _____ * _____/_____/_____

Provider Signature Provider Name (Print Name) Date of Signature (MM/DD/YYYY)

Do not fax/submit any copies of patient medical records. An incomplete Start Form may delay the start of treatment.