



MEDICARE FORM

Leqvio® (inclisiran) Medication Precertification Request

Page 1 of 2

(All fields must be completed and legible for precertification review.)

Virginia (HMO D-SNP)
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: For MAPD plans, Leqvio is non-preferred. Praluent is preferred through the Part D benefit. Repatha is also preferred for MAPD plans with open formularies. Leqvio is not subject to step therapy on MA only plans.

Please indicate: [] Start of treatment: start date ___/___/___ [] Continuation of therapy, date of last treatment ___/___/___
Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, Email, Patient Current Weight, Patient Height, and Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name, Medicare, and Medicaid.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, Office Contact Name, and Phone.

Specialty (Check one): [] Cardiologist [] Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Fields include Place of Administration (Self-administered, Physician's Office, Outpatient Infusion Center, Home Infusion Center, Administration code(s)), Dispensing Provider/Pharmacy (Physician's Office, Retail Pharmacy, Specialty Pharmacy, Other), Name, Address, Phone, Fax, TIN, PIN, and NPI.

E. PRODUCT INFORMATION

Request is for: Leqvio (inclisiran) Dose: _____ Frequency: _____ HCPCS Code: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the current LDL-C level in mg/dL: _____

For Initiation Requests (clinical documentation required):

Note: Leqvio is non-preferred on MAPD plans. Praluent is preferred through the Part D benefit. Repatha is also preferred for MAPD plans with open formularies. Leqvio is not subject to step therapy on MA only plans.

[] Yes [] No Has the patient had prior therapy with Leqvio (inclisiran) within the last 365 days?
[] Yes [] No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

[] Praluent (alirocumab) [] Repatha (evolocumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

[] Praluent (alirocumab) [] Repatha (evolocumab)

[] Yes [] No Will the patient continue to receive concomitant statin therapy?
[] Yes [] No Does the patient have intolerance or contraindication to high-intensity statin therapy?

Please indicate the prior therapy the patient has previously received (select all that applies to the patient):
[] The patient is receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily

Please indicate the start date: ___/___/___
[] Yes [] No Has the patient received this dose for at least 3 months?

[] Yes [] No Was the patient unable to tolerate a high-intensity statin due to adverse effects?

Continued on next page



MEDICARE FORM

Leqvio® (inclisiran) Medication Precertification Request

Page 2 of 2

(All fields must be completed and legible for precertification review.)

Virginia (HMO D-SNP)
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

For other lines of business:
Please use other form.

Note: For MAPD plans, Leqvio is non-preferred. Praluent is preferred through the Part D benefit. Repatha is also preferred for MAPD plans with open formularies. Leqvio is not subject to step therapy on MA only plans.

Patient First Name Patient Last Name Patient Phone Patient DOB

G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required) - continued:

- The patient is receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent
The patient has intolerance to a high-intensity statin therapy
The patient has contraindication to a high-intensity statin therapy

Clinical atherosclerotic cardiovascular disease (ASCVD)

Please indicate which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) the patient has experienced:

- Acute coronary syndrome
Coronary Artery Calcium (CAC) score of greater than or equal to 1000
Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery)
Myocardial infarction
Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD)
Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
Stable or unstable angina
Stroke of presumed atherosclerotic origin
Transient ischemic attack (TIA)
Other

Heterozygous familial hypercholesterolemia (HeFH)

- Does the patient possess an LDL-receptor mutation, familial defective apo B-100 or a PCSK9 mutation?
Please indicate the patient's untreated (before any lipid-lowering therapy) LDL-C level in mg/dL:
Please select which of the following applies to the patient:
Family history of myocardial infarction (MI) at less than 60 years of age in a first degree relative or less than 50 years of age in a second degree relative
Family history of total cholesterol (TC) greater than 290 mg/dL in a first/second degree relative
Presence of tendon xanthoma(s) in the patient or first/second-degree relative
None of the above- the patient does not meet any of the criteria listed above

For Continuation Requests (clinical documentation required):

- Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as the result of the requested medication therapy?
Please indicate which of the following applies to the patient:
The patient is currently receiving concomitant statin therapy
The patient has intolerance to a high-intensity statin therapy
The patient has contraindication to a high-intensity statin therapy

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): Date:

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.