LEQVIO® Service Center Start Form

Phone: 833-LEQVIO2 **Fax:** 877-537-8468 (877-LEQVIO8)

LEQVIO (inclisiran) injection 284 mg/1.5 mL

Welcome to the LEQVIO Service Center. We're here to assist you with getting LEQVIO for your patients.

Once this form is completed, we can offer full-service support, including:

- Insurance coverage review (includes benefits verification, prior authorization/appeals research)
- Benefits reverification approximately 30 days prior to patient's next treatment date
- Patient affordability support
- (Optional) The Service Center can initiate the transfer to an alternate treating site by sending the Start Form and the results of the coverage review to the site indicated on the next page

To request services, please follow these steps:

Step 1: Determine where your patient will receive treatment

Step 2: If your patient is going to be treated at an alternate treating site, find an appropriate site by visiting **LEQVIO-locator.com**

Step 3: Obtain authorization from your patient using one of the following methods:

Ask your patient to review page 3 and complete Section 4 on page 2

OR

Ask your patient to visit **servicecenter.ehipaa.com** or to scan the QR code

OR

Provide your patient with the Patient Consent Form available on **LEQVIOhcp.com/resources** or by scanning the QR code. Submit it along with this Start Form

Step 4: Complete all required fields (*) on this form. An incomplete Start Form may delay the start of treatment. **Do not fax/submit any copies of patient medical records**.
Optionally, if you would like the Service Center to initiate the transfer to an alternate treating site, please select the checkbox in Section 1 and ensure you complete the additional information required in Section 9. Remember, the Service Center will transfer this information only and does not guarantee that the order is complete. The Service Center does not accept clinical documentation and does not communicate with the treating site on your behalf

Step 5: Submit this form to the LEQVIO Service Center using one of two methods:

- Fax the completed form to **877-537-8468**, **OR**
- Electronically via the Service Center Portal by visiting **ServiceCenterPortal.com**

What happens next?

Once the Start Form is received by the LEQVIO Service Center, 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.

Administering in your office?

1. **Order LEQVIO** – Ensure your practice establishes an account with an authorized distributor before ordering and prepare for inventory storage needs
2. **Schedule the patient's appointment and administer LEQVIO** – For dosing and administration information, please visit **LEQVIOhcp.com**. Remember to help your commercially insured patients enroll in the LEQVIO Co-pay Program. Please visit **LEQVIOhcp.com/patient-support** for details
3. **Submit claim** – Use J-code J1306 along with the JZ modifier when submitting a claim for reimbursement[1,2]
4. **Submit co-pay claim** – Submit and manage claims for reimbursement. Please visit **LEQVIOhcp.com/patient-support** for details. Refer to the LEQVIO Billing and Coding Guide at **LEQVIOhcp.com/resources** for more information

Referring to an alternate treating site?

1. **If the Service Center is initiating the transfer to the alternate treating site**, the site may reach out to confirm additional information. If not, please send an order form directly to the site
2. **Send relevant clinical information** to the treating site. Refer to the LEQVIO Clinical Documentation Referral Checklist at **LEQVIOhcp.com/resources**
3. **Notify the patient** about the treating site details where they will receive their injection once the order is complete
4. **Follow up with treating site** and continue clinical care of the patient. Determine how future checkups and injections are scheduled

References: 1. Centers for Medicare & Medicaid Services. CMS HCPCS Application Summaries and Coding Recommendations: First Quarter, 2022 HCPCS Coding Cycle. Accessed August 5, 2025. 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 August 5, 2025. https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/jw-modifier-faqs.pdf

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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 diagnosis code; complete ICD-10-CM to the highest level of specificity)

Hypercholesterolemia: ☐ E78.00 ☐ E78.2 ☐ E78.49 ☐ E78.5 **Familial hypercholesterolemia:** ☐ E78.011 ☐ E78.019

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)

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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.

The LEQVIO Service Center or the LEQVIO Care Program 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.

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. Per-treatment maximums and an annual benefit cap apply. 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 Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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