

LEQVIO® Co-pay Claim Request Form



Pick **only one** checkbox option below.

I am a patient/authorized representative filling out the form to get money back

OR

I am a patient/authorized representative filling out the form to have my payment go right to my doctor

I am a health care provider

If you are a health care provider, fill out page 2 and review the co-pay program terms and conditions on page 3. Then, send all 3 pages to the LEQVIO Co-pay Program to see if your patient is eligible for co-pay support.

If you are a patient/authorized representative, fill out page 1 and read the co-pay program terms and conditions on page 3. Then, send all 3 pages to the LEQVIO Co-pay Program to see if you may be able to get co-pay support.

For patients/authorized representatives

How to see if you may be able to get co-pay support

1. Fill out all the information on this page
2. Read and sign the certification statement at the bottom of this page
3. Mail this form to: **LEQVIO Co-pay Program, 430 Mountain Avenue, Suite 105, New Providence, NJ 07974** or fax this form to **1-908-548-9364**
4. Send all required information (see *below*) to the LEQVIO Co-pay Program with all 3 pages of this form

Patient information

= REQUIRED FIELDS

* First name: _____ * Last name: _____
* ZIP Code: _____ * Date of birth: _____ Male Female Other
* Phone: _____ Email (optional but recommended): _____
* Group number: _____ * Member ID number: _____
(ie, EX00000000, from the LEQVIO Co-pay ID card on the Welcome Letter) (11-digit ID from the LEQVIO Co-pay ID card on the Welcome Letter)

Authorized representative information (required for pediatric patients [aged 12-17 years])

First name: _____ Last name: _____
Relationship to patient: Parent Legal guardian Other: _____
Phone: _____ Email (optional but recommended): _____

Co-pay claim payment information

Pick **only one** checkbox option below.

I paid my doctor for LEQVIO. I am requesting to be paid back (receipt is required)

Write your name and home address below:

* Check payable to: _____
* Street address: _____
* City: _____ * State: _____
* ZIP Code: _____
* Provider name: _____
* Provider phone: _____

I did not pay my doctor for LEQVIO. I am asking for my doctor to be paid on my behalf

Write your doctor's office name and address below (ask your doctor for the right mailing address):

* Check payable to: _____
* Provider name: _____
* Street address: _____
* City: _____ * State: _____
* ZIP Code: _____ * Phone: _____

* Required information to send

To send a claim, you will need to also provide:

- **Explanation of Benefits (EOB)** from your insurance provider. EOB must show patient name, date of service, and amount billed and paid for LEQVIO (J1306). Any other fees should be listed separately. If this information is missing, please obtain a CMS-1500 or CMS-1450/UB-04 from your doctor's office and submit with this claim
 - A copy of the front and back of your **insurance card(s)**
 - **Proof of payment** (a receipt is required if you are requesting to be paid back)
- If any of the above is missing, the claim will not be paid.**

THEN

Mail to:
**LEQVIO Co-pay Program
430 Mountain Avenue, Suite 105
New Providence, NJ 07974**

OR

Fax to **1-908-548-9364**

Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

* **Acknowledged and agreed (signature required):**

Print Name: _____ Signature: _____ Date: _____

For health care providers (HCPs) only

The fields below are required to be filled out **only** by HCPs. If the claim is approved, reimbursement will be provided via check.

Administering provider

 = REQUIRED FIELDS

* Practice name: _____

* Provider first name: _____ * Provider last name: _____

* Provider's NPI: _____ * Site NPI: _____

* Site address: _____

* Site city: _____ * Site state: _____ * Site ZIP Code: _____

* Primary site contact: _____ * Primary site phone: _____ Ext. _____

Patient information

* Patient first name: _____ * Patient last name: _____

* ZIP Code: _____ * Date of birth: _____ Male Female Other

* Patient group number: _____ * Patient member ID number: _____
(ie, EX00000000, from the LEQVIO Co-pay ID card on the Welcome Letter) (11-digit ID from the LEQVIO Co-pay ID card on the Welcome Letter)

Co-pay claim payment information

* Check payable to: _____

* Provider payment remittance address (if different from site address): _____

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

Email address: _____

Fax number: _____ * NPI number: _____ * Tax ID number: _____

*** Please fax all 3 pages of this form and the following documents to 1-908-548-9364 to complete the process. Payments will not be processed without the following items.**

Provide the Explanation of Benefits (EOB), which must include:

- Patient name • Date of service
- Amount billed and paid for LEQVIO or J-code J1306 only. Any other fees should be listed separately

If the EOB does not include the above information, please also provide a CMS-1500 or CMS-1450/UB-04 form.

Certification Statement

I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by insurance, a flexible spending account (FSA), health savings account (HSA), or any other payer. I certify that the patient is not covered under Medicare, Medicaid, TRICARE, VA, DoD, or any other government (state or federally funded) program and that my use of this form is not prohibited by federal or state law. I understand and agree that I am liable for any misrepresentations herein to the full extent of applicable law.

*** Acknowledged and agreed (signature required):**

Print Name: _____ Signature: _____ Date: _____

Send all information needed to:

Mail to:

**LEQVIO Co-pay Program
430 Mountain Avenue, Suite 105
New Providence, NJ 07974**

OR

Fax to:

1-908-548-9364



Have questions? Contact the LEQVIO Co-pay Program at 1-833-277-7542.

LEQVIO Co-pay Program Terms & 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.