



LEQVIO® Provider Co-pay Portal Guide



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Program Overview



- Through the LEQVIO Co-pay Program, eligible patients with commercial insurance may pay as little as \$0
- **Co-pay Eligibility***
 - Commercially insured patients only
 - Patients over 12 years of age
 - Residents of the United States or Puerto Rico
 - Excluded from this offer: Cash-paying patients, patients covered by any state or federal health program, including but not limited to Medicare, Medicaid, Medicaid Advantage, Medigap, VA, DoD, or TRICARE, as well as patients' insurance where product is not covered
 - Additional limitations apply. See full 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.

Portal Overview

The purpose of this document is to provide step-by-step instructions on the use of the LEQVIO® (inclisiran) Provider Co-Pay Portal. The Portal is utilized for the submission of claims for reimbursement where the prescription is covered by medical benefits.

- Within the LEQVIO Provider Co-pay Portal, user will be able to:
 - Enroll a patient and obtain a co-pay card for manual medical claims adjudication
 - Search for previously established patients
 - Submit a medical claim to IQVIA for claims adjudication

Providers/Alternate Sites of Care (ASOC) can access the Provider Co-pay Portal directly at <https://hcpcopayportal.opushealth.com>

Account Registration



Registration: New Health Care Provider and ASOC Registration



[Provider Co-pay Portal](#)[Authorization Form](#)[Portal User Guide](#)

Welcome to Provider Co-pay Portal

Submit co-pay claims for in-office administered therapy.

Before you begin using the LEQVIO® (inclisiran) Provider Co-pay Portal, you will need to register your practice. Once registered you will be able to:

- Enroll eligible patients in the co-pay program
- Submit claims for reimbursement
- Track claim submissions

This process will take only a few minutes. If you have questions about the portal or have any difficulty registering, please give us a call at 833-277-7542.

Please note: This program is only available for patients that are commercially insured and are not participating in VA, Tricare, CHAMPUS, Medicaid, or any other similar federal or state program. Your information will be shared with Novartis Pharmaceuticals Corporation and used in accordance with its Privacy Policy. Please click [here](#) to view the [NPC Privacy Policy](#)

Sign in

Email

Password [Forgot password?](#)

☐ Remember my email

[Sign In](#) or [register your practice](#)

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- To register an account, select “register your practice”
- To access the HCP Co-pay Portal User Guide, select “Portal User Guide” in the upper right corner
- To view and download a blank Patient Authorization Form, select “Authorization Form”

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal

Authorization FormPortal User Guide

Create Practice Account

Introduction

To begin, a representative from the practice must complete the practice registration process.

Before you may begin using the Provider Co-pay Portal, each user within the practice must activate his or her own account individually.

User activation does not have to be completed at the time of practice registration, but must be completed before you may begin using Provider Co-pay Portal.

You will need the following information in order to successfully register your practice:

1. User information including email address (you may add additional users at a later date)
2. Practice location information
3. Healthcare Provider National Provider Identifier (NPI)

You will be asked to agree to the Provider Co-pay Portal Agreement. You must agree to these terms to proceed with Provider Co-pay Portal.

Begin

- Users are required to review the practice registration requirements to ensure all the information is available during the registration process. Click on “Begin” to access the registration page

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal

Create Practice Account About The Practice

Please enter the information requested below. We will use this information to verify your practice.

Practice Name	Practice NPI
Street Address	
Address Line 2 (optional)	
City	
State	ZIP
Phone	Email Address
Remittance Address ☐ Same as practice address	
If reimbursements should be mailed to an address other than the practice address, indicate the remittance address here.	
Street Address	
Address Line 2 (optional)	
City	
State	ZIP
Payment Method	
You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.	
Claim Status Updates	
Notifications for check payments are sent by direct mail to the mailing address above.	
If you would like fax notifications for EFT payments, enter your fax number below.	
☐ Receive EFT payment updates at this fax number:	
Next	

- **Create Practice Account - About The Practice** – If the practice has elected to receive payments via Electronic Funds Transfer (EFT), upon successful practice registration, the administrator user will receive a separate email to setup their EFT account which will contain a link that will take them to the EFT SSO site to add their bank account information for EFT payments
- If the practice would like to receive EFT payment updates by fax, click the box next to “Receive EFT payment updates at this fax number:” and provide a valid fax number. Once all the information is complete, click “Next”
- If the practice has elected to receive payments by check, notifications will be sent by direct mail to the practice address listed

Registration: New Health Care Provider and ASOC Registration (cont)



Create Practice Account About The Practice

Please enter the information requested below. We will use this information to verify your practice.

Practice Name Practice NPI
Name is required. NPI is required.

Street Address
Street Address is required.

Address Line 2 (optional)

City
City is required.

State ZIP
State is required. ZIP is required.

Phone Email Address
Phone is required. Email Address is required.

Remittance Address ☐ Same as practice address

If reimbursements should be mailed to an address other than the practice address, indicate the remittance address here.

Street Address
Street Address is required.

Address Line 2 (optional)

City
City is required.

State ZIP
State is required. ZIP is required.

Payment Method

You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.

Check

Claim Status Updates

Notifications for check payments are sent by direct mail to the mailing address above.

If you would like fax notifications for EFT payments, enter your fax number below.

☐ Receive EFT payment updates at this fax number:

Next

- All fields are required (except for Address Line 2) to validate the account, register, and provide access, including patient enrollment and claim submission
- If registering a multi-practice location account, please use the corporate NPI number of your larger organization to create one portal account for all individual practice locations
- If registering a multi-practice location account but choosing to keep each location as a separate portal account, please use the individual site NPI number to register

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal Authoriz

Create Practice Account

About You

We will send an activation link to your email address within three business days. This is required to access the co-pay portal.

Email Address Your activation email will be sent to this address.

First Name

Last Name

Phone Number Extension (optional)

Role in Practice

Next

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- **Create Practice Account - About You** - Enter the contact information for the primary user submitting claims for reimbursement. This user will automatically be set as an administrator, allowing them to add/edit practice, users, and provider information. Click “Next” to continue the registration process

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal Author

Create Practice Account

About You

We will send an activation link to your email address within three business days. This is required to access the co-pay portal.

Email Address Your activation email will be sent to this address.

First Name

Last Name

Phone Number **Extension (optional)**

(###) ###-####

Role in Practice

- Office/Billing Administrator
- Medical Doctor
- Nurse – Non-Prescribing
- Nurse Practitioner
- Physician's Assistant
- Other

- The user is required to select a “Role in Practice”

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal Authoriz

Create Practice Account

About You

We will send an activation link to your email address within three business days. This is required to access the co-pay portal.

Email Address Your activation email will be sent to this address.

Email is required.

First Name

First Name is required.

Last Name

Last Name is required.

Phone Number **Extension (optional)**

Phone is required.

Role in Practice

User Role is required.

Next

- All fields are required on this screen except for “Extension”

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal [Authorization Form](#) [Portal User Guide](#)

Create Practice Account Additional Users

You can add up to three additional users during registration. More users can be added after your practice is approved.

Name	Email Address	Role	Admin	
Test1 Test	poojadave1@iqvia.com	Other	☒	Edit

[Add a User](#)

[Next](#)

- **Create Practice Account - Additional Users -**
Provides the ability to add users to the Practice Account
- If adding users, click on the “Add a user” link and follow the same process as in the previous step. If additional users do not need to be added at this time, click on “Next”

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Provider Co-pay Portal [Authorization Form](#) [Portal User Guide](#)

Create Practice Account Additional Users

You can add up to three additional users during registration. More users can be added after your practice is approved.

Name	Email Address	Role	Admin	
Test1 Test	poojadave1@iqvia.com	Other	☒	Edit

[Add a User](#)

[Next](#)

User

Email Address An activation email will be sent to this address.

First Name

Last Name

Phone Number (###) ###-#### Extension

Role In Practice Administrators can manage users and providers at the practice.

☐ Administrator

[Save](#) [Cancel](#)

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Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal Authoriz

Create Practice Account

About You

We will send an activation link to your email address within three business days. This is required to access the co-pay portal.

Email Address Your activation email will be sent to this address.

First Name

Last Name

Phone Number Extension (optional)

Role in Practice

[Next](#)

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- In Create Practice Account - Additional Users (previous page), click the Edit link
- **Create Practice Account - About You** - Provides the ability to edit user's information
- Once changes are made, click "Next" and it will route back to "Create Practice Account – Additional Users" screen

Registration: New Health Care Provider and ASOC Registration (cont)



Provider Co-pay Portal

Create Practice Account

About the Provider

At least one provider from your practice must be added in order to verify the practice.

Provider First Name

Provider Last Name

NPI Number

State License Number (optional)

Provider Type

Next

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- Create Practice Account - About the Provider - Enter the contact information for a provider that will be included on the submitted forms for claims reimbursement
- If there is more than one provider in the practice, the user will be provided an opportunity to add providers on the next screen. Once the information is complete, click on “Next”

Registration: New Health Care Provider and ASOC Registration (cont)



Provider Co-pay Portal

About the Provider

At least one provider from your practice must be added in order to verify the practice.

Provider First Name

First Name is required.

Provider Last Name

Last Name is required.

NPI Number

NPI Number is required.

State License Number (optional)

Provider Type

Provider Type is required.

Next

- All fields (except State License Number) are required on this screen

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Registration: New Health Care Provider and ASOC Registration (cont)



Provider Co-pay Portal

Authorization FormPortal User Guide

Create Practice Account

Additional Providers

You can add up to three additional providers during registration. More providers can be added after your practice is approved.

Name	NPI	SLN	Type	
Test7 Test7	7433333333		Medical Doctor	Edit

Add a Provider

Next

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- **Create Practice Account - Additional Providers** - Review the Practice, Users, and Providers information carefully, and if no revisions are required, click on “Next”

Registration: New Health Care Provider and ASOC Registration (cont)

[Provider Co-pay Portal](#)[Authorization Form](#)[Portal User Guide](#)

Create Practice Account

Additional Providers

You can add up to three additional providers during registration. More providers can be added after your practice is approved.

Name	NPI	SLN	Type	
Test7 Test7	7433333333		Medical Doctor	Edit

[Add a Provider](#)

[Next](#)

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- If any information needs to be corrected, click on the “Edit” link next to the appropriate section

Registration: New Health Care Provider and ASOC Registration (cont)



Provider Co-pay Portal

Create Practice Account

About the Provider

At least one provider from your practice must be added in order to verify the practice.

Provider First Name

Provider Last Name

NPI Number

State License Number (optional)

Provider Type

Medical Doctor ▼

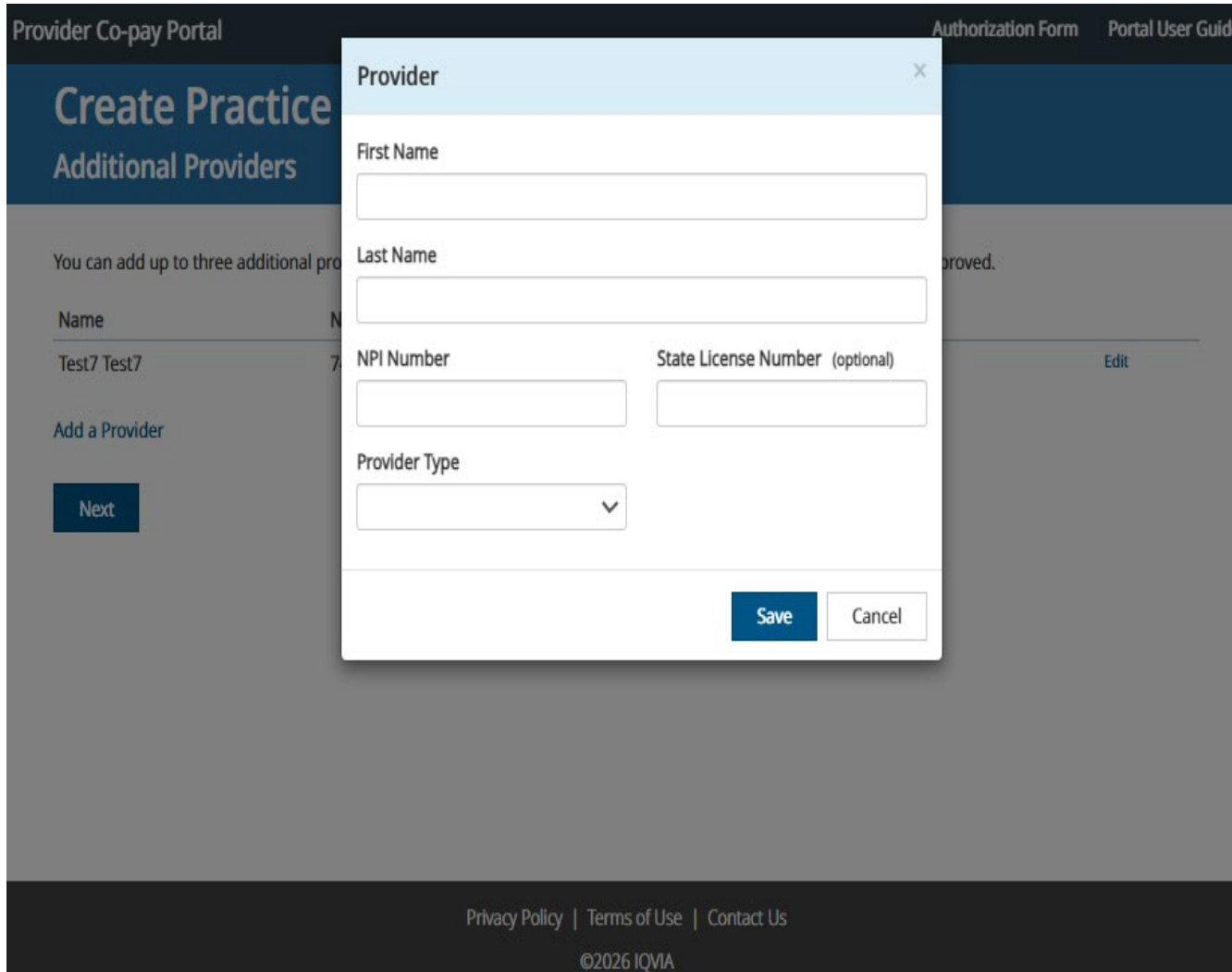
Next

- Practice Account, Users, and Providers information can be changed within the portal after registration by following the instructions in the associated sections

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Registration: New Health Care Provider and ASOC Registration (cont)



The screenshot displays the 'Provider Co-pay Portal' interface. A modal window titled 'Provider' is open, allowing for the addition of new providers. The modal contains the following fields:

- First Name**: A text input field.
- Last Name**: A text input field.
- NPI Number**: A text input field.
- State License Number (optional)**: A text input field.
- Provider Type**: A dropdown menu with a downward arrow.

At the bottom of the modal are two buttons: **Save** (in a blue box) and **Cancel** (in a white box with a grey border). The background of the portal shows a table with the header 'Name' and a row containing 'Test7 Test7'. A 'Next' button is visible in the background, and a footer contains links for 'Privacy Policy', 'Terms of Use', and 'Contact Us', along with the copyright notice '©2026 IQVIA'.

- In Create Practice Account - Additional Providers, to add providers, click on the “Add a provider” link
- Once user has completed entering in the provider’s information, click on “Save”
- If additional users do not need to be added at this time, in Create Practice Account - Additional Providers, click on “Next”

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal

Authorization Form

Portal User Guide

Create Practice Account

Review Registration

Please review the information below before submitting your registration.

Practice

Edit

TestPractice 5

NPI: 1234567812

Phone: (655) 555-5555

Address:
1301 Skittles Way
Fort Worth, TX 76191

Payments will be received by check.
Claim status updates will be sent to **pdave@us.imshealth.com**.

Next

Users

Edit

Name	Email Address	Role
PTest Ptest1	pdave1@iqvia.com	Other

Providers

Edit

Name	NPI	SLN
Test7 Test7	7433333333	

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- In Create Practice Account - Review Registration, review the Practice, Users, and Providers information carefully, and if no corrections are required, click on “Next”
- If any information needs to be corrected, click on the “Edit” link next to the appropriate section

Registration: New Health Care Provider and ASOC Registration (cont)

Provider Co-pay Portal Authorization Form Portal User Guide

Create Practice Account
Practice Agreement

Please sign below the following Terms and Conditions to indicate your understanding and acceptance of the terms and conditions of participation of this HCP Medical Co-pay Program.

I certify that the information provided in claims submitted to IQVIA Inc., Patient Access and Affordability Solutions Division as part of this HCP Medical Co-pay Program will be accurate; that expenses requested for payments will be eligible patient co-pay, co-insurance, or deductible expenses, actually incurred and not paid by the patient's insurance, Flexible Spending Account, Health Savings Account, or any other payer; and that I would, in the ordinary course of my practice, have charged my patient for such out-of-pocket expenses. I also certify that I will ensure that each patient for whom submits documentation under this Program (i) will not be purchasing their prescriptions with benefits from Medicare, including Medicare Part D or Medicare Advantage Plans; Medicaid, including Medicaid Managed Care or Alternative Benefit Plans ("ABPs") under the Affordable Care Act; Medigap; Veterans Administration ("VA"); Department of Defense ("DoD"); TRICARE®; or any similar state-funded programs, such as medical or pharmaceutical assistance programs; and (ii) will meet the other eligibility criteria for the program. Any other expenses, including, but not limited to, out-of-network amounts not covered by patient's insurance, are not eligible for payment under this Program. I understand that I am liable for any misrepresentations herein to the full extent of applicable law.

I also understand that IQVIA reserves the right to verify submitted claims information at any time.

☐ Acknowledged and Agreed

Enter your name to accept

PTest

PTest1

☐ I'm not a robot

reCAPTCHA

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- **Create Practice Account - Practice Agreement:** The last step in the registration process is to read the Terms and Conditions and click the checkbox next to “Acknowledged and Agreed”
- Enter the first and last name of the main user, click on the box next to “I’m not a robot,” and select “Finish”

Registration: New Health Care Provider and ASOC Registration (cont)

[Provider Co-pay Portal](#)[Authorization Form](#)[Portal User Guide](#)

Create Practice Account

Registration Successful

✓ **Your registration was successfully submitted.**

Thank you for registering your practice for Provider Co-pay Portal. We are currently processing your request. You and any users added during registration will receive an account notification email within two (2) business days.

Please note, you will not be able to sign in until your practice has been approved and your account is activated.

[Done](#)

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- **Creating Practice Account - Registration Successful:** A confirmation page will show that the registration was successful
- Click on “Done” to close the screen. The information submitted will be validated by the IQVIA Program Support team. If clarification is required before the validation can occur, the IQVIA Program Support team will reach out to the main user on the account. A confirmation email will also be sent to the user

Registration: Practice Registration Email Confirmation

Practice Registration Submitted

Hello Test,

Thank you for registering your practice for Provider Co-pay Portal. We are currently processing your request. You and any users added during registration will receive an account notification email within two (2) business days.

Thank you,
Customer Support

Please do not reply to this message, which was sent from an unmonitored e-mail address.

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- Users will receive a practice registration submission confirmation email

Registration: Registration Confirmation

Activate Your Practice User Account

Hello Mike,

Welcome to Provider Co-pay Portal! Your practice has been validated. Please click the button below to activate your login account and start submitting claims.

Your link will be valid for 14 days from the date of this email.

Activate User

If you're having trouble clicking the activation button, copy and paste the URL below into your web browser.

<https://uat.opushealth.com/InclisiranBuyAndBill/Home/ActivateAccount?username=michael.ferguson2@quintilesims.com&code=2162524722711713518313518645217569551139561015716869945022418147>

Thank you,
Provider Co-pay Portal Support

Please do not reply to this message, which was sent from an unmonitored e-mail address.

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- Practice Registration Email Confirmation - Once the IQVIA Program Support team has validated the account, an email will be sent to the main user with a link to activate the account and finish the account setup. The link in the email will be valid for 14 days from the date of the email

New User Setup

Provider Co-pay Portal

Reset Your Password

New Password

Confirm Password

Save Cancel

Your password should have:

- at least 1 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & + =

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- Upon clicking the button “Activate User” or the hyperlink provided (previous page), the password setup screen will be displayed. The password must meet the following criteria:
 1. At least 8 characters
 2. At least 1 lowercase letter (a-z)
 3. At least 1 uppercase letter (A-Z)
 4. At least 1 number (0-9)
 5. At least 1 special character, such as ! @ # \$ % ^ & + =

Registration: Registration Validation

Invalid Activation Code

 **Your activation code is invalid or expired.**

You can get another activation email, or contact customer support for assistance.

Resend Email

Need help?

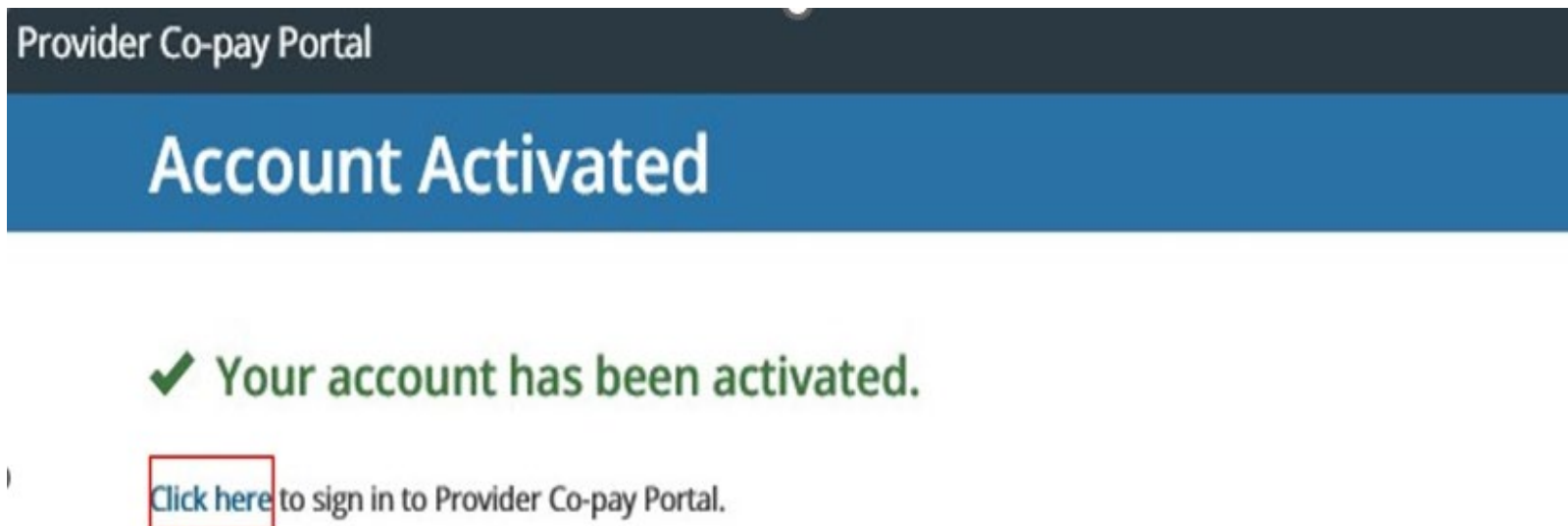
Call Customer Support

(833) 277-7542

8:00 AM - 8:00 PM ET Mon-Fri

- **Activation Error Message** - If the activation link expires and the user clicks on the link, the following error will be displayed with instructions to contact IQVIA for assistance

Registration: Registration Validation (cont)



- Once active, the Account Activated confirmation screen will display
- Selecting “Click here” will take user to the portal sign-in page

Provider Co-pay Portal Navigation



Login Instructions – Login Homepage



Provider Co-pay Portal

[Authorization Form](#) [Portal User Guide](#)

Welcome to Provider Co-pay Portal

Submit co-pay claims for in-office administered therapy.

Before you begin using the LEQVIO® (inclisiran) Provider Co-pay Portal, you will need to register your practice. Once registered you will be able to:

- Enroll eligible patients in the co-pay program
- Submit claims for reimbursement
- Track claim submissions

This process will take only a few minutes. If you have questions about the portal or have any difficulty registering, please give us a call at 833-277-7542.

Please note: This program is only available for patients that are commercially insured and are not participating in VA, Tricare, CHAMPUS, Medicaid, or any other similar federal or state program. Your information will be shared with Novartis Pharmaceuticals Corporation and used in accordance with its Privacy Policy. Please click [here](#) to view the [NPC Privacy Policy](#)

Sign in

Email

Password

[Forgot password?](#)

☐ Remember my email

[Sign In](#) or [register your practice](#)

- Once the user has successfully created a password, the Welcome to Provider Co-pay Portal screen will display. The user can log in to the portal by entering the email and password. Upon completion of both fields, click “Sign In” to access the portal

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Login Instructions – Reset Password

Provider Co-pay Portal Authorization Form Portal User Guide

Welcome to Provider Co-pay Portal

Submit co-pay claims for in-office administered therapy.

Before you begin using the LEQVIO[®] (inclisiran) Provider Co-pay Portal, you will need to register your practice. Once registered you will be able to:

- **Enroll eligible patients in the co-pay program**
- **Submit claims for reimbursement**
- **Track claim submissions**

This process will take only a few minutes. If you have questions about the portal or have any difficulty registering, please give us a call at 833-277-7542.

Please note: This program is only available for patients that are commercially insured and are not participating in VA, Tricare, CHAMPUS, Medicaid, or any other similar federal or state program. Your information will be shared with Novartis Pharmaceuticals Corporation and used in accordance with its Privacy Policy. Please [click here](#) to view the NPC Privacy Policy

Sign in

Email

Password [Forgot password?](#)

Password is required.

☐ Remember my email

[Sign In](#) or [register your practice](#)

- If the user has entered incorrect login information, an error message will display. If the user has forgotten their password, follow the steps outlined on the following page to reset the password

Login Instructions – Reset Password (cont)

Provider Co-pay Portal

Authorization FormPortal User Guide

Welcome to Provider Co-pay Portal
Submit co-pay claims for in-office administered therapy.

Before you begin using the LEQVIO[®] (inclisiran) Provider Co-pay Portal, you will need to register your practice. Once registered you will be able to:

- Enroll eligible patients in the co-pay program
- Submit claims for reimbursement
- Track claim submissions

This process will take only a few minutes. If you have questions about the portal or have any difficulty registering, please give us a call at 833-277-7542.

Please note: This program is only available for patients that are commercially insured and are not participating in VA, Tricare, CHAMPUS, Medicaid, or any other similar federal or state program. Your information will be shared with Novartis Pharmaceuticals Corporation and used in accordance with its Privacy Policy. Please click here to view the [NPC Privacy Policy](#)

Sign in

Email

Email

Password

Password

Forgot password?

☐ Remember my email

Sign In

 or register your practice

- If the user cannot remember their password, click on the “Forgot password?” link on the Welcome screen

Login Instructions – Reset Password (cont)

[Provider Co-pay Portal](#)[Authorization Form](#)[Portal User Guide](#)

Reset Your Password

Please enter the email address associated with your account. You will receive an email with a link to reset your password.

You will only receive an email if your practice has been approved and your email address has been registered at the practice.

Email Address

☐ I'm not a robot

Send Email

- Enter the email address associated with the user's account and click "Send Email"

Login Instructions – Reset Password (cont)

Provider Co-pay Portal

Authorization Form Portal User Guide

Reset Your Password

✓ Password Reset Sent

Click the link in your email to reset your password.

If a valid account was found for your email address, we have sent you a password reset link. Please check your inbox for an email from donotreply@opushealth.com.

If you do not see the email, please check your junk mail folder and make sure pdave@us.imshealth.com is the correct email address for your Provider Co-pay Portal account. You can also [click here](#) to receive a new link.

Need help?

Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

- **Forgot password request screen -**
A reset password confirmation screen will display

Login Instructions – Reset Password (cont)



Reset Your Provider Co-pay Portal Password

Hello Pooja,

You recently asked to reset your Provider Co-pay Portal password by e-mail. Please click the button below to reset your password. Your reset link will be valid for 24 hours.

Reset Password

If you're having trouble clicking the password reset button, copy and paste the URL below into your web browser.

<https://uat.opushealth.com/inclisiranBuyAndBill/Home/ResetPassword?username=pdave%40us.imshealth.com&code=5113675191792161188042772005116915980301181641111501932122932492>

If you are still unable to access your account, or if you did not request a password reset, please [contact support](#).

Thank you,
Customer Support

Please do not reply to this message, which was sent from an unmonitored e-mail address.

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- The user will receive an email with instructions on how to reset their password. The user can click the “Reset Password” button or the hyperlink provided

Login Instructions – Reset Password (cont)

Provider Co-pay Portal

Authorization FormPortal User Guide

Reset Your Password

New Password

Confirm Password

SaveCancel

Your password should have:

- at least 1 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & + =

- Once the user has either clicked the “Reset Password” button or the hyperlink provided (previous page), the Reset Your Password window will be displayed
- Enter the new password following the password requirements shown on the right side of the screen
- The same password must be entered in the New Password and Confirm Password fields. Once both fields have been updated with the new password, click on the “Save” button

Login Instructions – Reset Password (cont)

Provider Co-pay Portal

Authorization FormPortal User Guide

Reset Your Password

New Password

The New Password field is required.

Confirm Password

The Confirm Password field is required.

Save

Cancel

Your password should have:

- at least 1 characters
- at least 1 lowercase letter (a-z)
- at least 1 uppercase letter (A-Z)
- at least 1 number (0-9)
- at least 1 special character, such as ! @ # \$ % ^ & + =

- If the password requirements have not been met, the user will receive an error message. Re-enter a new password following the instructions on the right side of the screen, ensuring the password is the same for both the New Password and Confirm Password fields

Login Instructions – Reset Password (cont)



Reset Your Password

! Sorry, your reset code is invalid or expired.

Please [click here](#) to try again.

Need help?

Call Customer Support

(833) 277-7542

8:00 AM - 8:00 PM ET Mon-Fri

Login Instructions – Reset Password (cont)

[Provider Co-pay Portal](#) [Home](#) [Claims ▾](#) [Practice ▾](#) [Contact Us](#) [pdave@us.imshealth.com ▾](#)

Welcome, Pooja

✔ Your password has been updated. ✕

[Submit a Claim](#) [Add a Patient](#)

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▼	Date Updated	Claim Amount
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View
New Claim	128071	K53100114132	TEST, TEST	Butler, Keith		8/11/2022		View

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- Upon the successful submission of a new password, the following screen will be displayed confirming the password has been updated

Submitting a Claim

Provider Co-pay Portal

Home

Claims ▾

Practice ▾

Contact Us

pdave@us.imshealth.com ▾

Welcome, Pooja

Submit a Claim

Add a Patient

Need help?

Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Change Password

Sign Out

Pending Claims

See all claims

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View
New Claim	128071	K53100114132	TEST, TEST	Butler, Keith		8/11/2022		View

First

1

2

Last

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- Upon signing in to the Provider Co-pay Portal, a user will be able to perform the following functions:
 1. View Claims History & Submit a Claim
 2. Enroll a Patient & Obtain a Co-pay Card
 3. Update Practice Information
 4. Update or add Users, Providers, or Patients
 5. Use the dropdown menu on the far right under the email address to change a password or log out of the portal
- “Enroll a Patient & Obtain a Co-pay Card” selection will be used for all new patients

Submitting a Claim (cont)

Provider Co-pay Portal Home **Claims** Practice Contact Us pdave@us.imshealth.com

Welcome, P **Submit a Claim**
Claim History

Submit a Claim Add a Patient

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▼	Date Updated	Claim Amount	
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026			View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025			View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024			View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024			View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023			View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023			View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023			View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023			View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022			View
New Claim	128071	K53100114132	TEST, TEST	Butler, Keith		8/11/2022			View

First **1** 2 Last

- From the Welcome Screen, the user can select the “Submit a Claim” button or Submit a Claim from the Claims dropdown menu. The patient must be added to the portal to submit a claim. This can be done during the claims submission process. If the user wants to add patients prior to submitting claims, they can do so by following the instructions on slide 70 “Add a Patient”

Submitting a Claim (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Submit a Claim

Patient [New Patient](#) Provider



Please provide the explanation of benefits (EOB), which must include:

- Patient name
- J Code or drug name
- Date of service

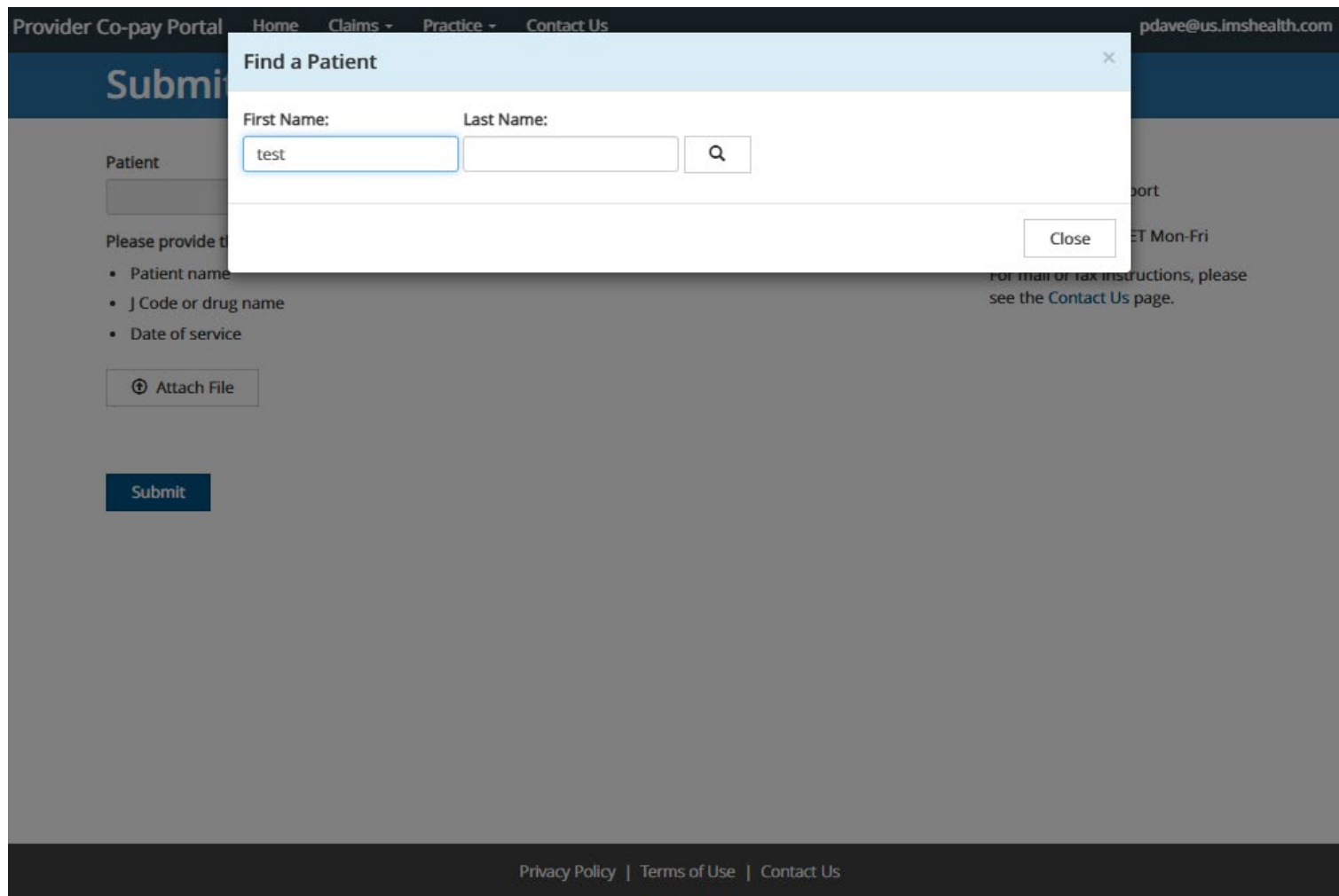
 Attach File

[Submit](#)

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri
For mail or fax instructions, please see the [Contact Us](#) page.

- To submit a claim for an existing patient, click on the search icon (magnifying glass) to display the patient search field

Submitting a Claim (cont)



The screenshot displays the 'Provider Co-pay Portal' interface. A modal window titled 'Find a Patient' is open, featuring two input fields: 'First Name:' with the text 'test' and 'Last Name:'. A magnifying glass icon is positioned to the right of the 'Last Name' field. A 'Close' button is located at the bottom right of the modal. The background shows a 'Submit' button and a list of required information: Patient name, J Code or drug name, and Date of service. An 'Attach File' button is also visible.

- Users can enter a First Name and Last Name and then select the magnifying glass

Submitting a Claim (cont)

Provider Co-pay Portal Home Claims Practice Contact Us pdave@us.imshealth.com

Submit

Patient

Please provide the following information:

- Patient name
- J Code or drug
- Date of service

Attach File

Submit

Find a Patient

First Name: Last Name:

Name	Date Of Birth	ZIP	
TESTONE TESTONE	01/01/1971	08807	View Submit Claim

Close

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- Click the Submit Claim link. Upon clicking this link, the screen will revert to the Submit a Claim window and the selected patient's name will be populated in the Patient field

Submitting a Claim (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Submit a Claim

Patient New Patient Provider

TESTONE TESTONE Pooja Dave

Please provide the explanation of benefits (EOB), which must include:

- Patient name
- J Code or drug name
- Date of service

  TEST.pdf 

- To complete the submission, ensure the correct provider is selected and the correct documentation is attached. The documentation must be in one of the following formats: picture file (jpg, jpeg, gif, png, bmp, tif, tiff) or PDF. Once these 2 steps are complete, click on Submit, and a confirmation page will display acknowledging a successful submission

Submitting a Claim (cont)

Claim Submitted

✓ **The claim has been successfully submitted.**

The confirmation number is 149890.

You will be notified once the claim is approved.

[Back to home page](#)

- The user can click on “Back to home page” to return to the Welcome screen or select another function using the dropdown menus within the header

Submitting a Claim (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Welcome, Pooja

[Submit a Claim](#)[Add a Patient](#)

Need help?

Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims

[See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

First 1 2 Last

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- When the “Back to home page” selection (previous page), the Welcome screen will be displayed containing the recent claims submitted. To view a submitted claim, click on the View link on the far right

Submitting a Claim – Claim Details

[Provider Co-pay Portal](#) [Home](#) [Claims ▾](#) [Practice ▾](#) [Contact Us](#) [pdave@us.imshealth.com ▾](#)

Claim Details

Status	New Claim	Attached Files TEST.pdf TestOne.pdf
Confirmation Number	149890	
Patient	TESTONE TESTONE	
Provider	Pooja Dave	
Date Submitted	5/4/2026	
Payment Method	Electronic	
Co-pay Card GRP #	OH7142011	
Co-pay Card ID #	K53100114206	
Submitted By	pdave@us.imshealth.com	

Ok

- The screen will display the details of the submitted claim selected by the user

Claim History

Provider Co-pay Portal Home **Claims ▾** Practice ▾ Contact Us pdave@us.imshealth.com ▾

Welcome, Pdave ▾

Submit a Claim
Claim History

[Submit a Claim](#)[Add a Patient](#)**Need help?**

Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims[See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

[First](#) **1** [2](#) [Last](#)

- A user can view a list of the submitted claims by selecting the Claim History option from the Claims dropdown menu within the header

Claim History

Claim History

Submit a Claim

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted	
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026	Download claim history As Excel As CSV View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026	View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025	View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024	View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024	View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023	View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023	View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023	View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023	View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022	View

First 1 2 Last

- Once in the Claim History section, a user can view a list of all submitted claims.
- Users can also choose to download their claim history list by selecting “Download claim history” and choosing the file type they wish, either Excel or CSV.

Claim History – View

[Provider Co-pay Portal](#) [Home](#) [Claims ▾](#) [Practice ▾](#) [Contact Us](#) [pdave@us.imshealth.com ▾](mailto:pdave@us.imshealth.com)

Welcome, Pooja

[Submit a Claim](#) [Add a Patient](#)

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

[First](#) [1](#) [2](#) [Last](#)

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- To view an individual claim, click on the “View” link. The Claim Details screen will be displayed as shown on slide 52

Claim History – View (cont)



Claim Details

Status	New Claim
Confirmation Number	149658
Patient	KEITH BUTLER
Provider	Pooja Dave
Date Submitted	4/22/2026
Payment Method	Electronic
Co-pay Card GRP #	OH7142071
Co-pay Card ID #	L86100106434
Submitted By	pdave@us.imshealth.com

Ok

Attached Files

TEST.pdf

Viewing and Editing Practice Account Information

Provider Co-pay Portal Home Claims Practice Contact Us pdave@us.imshealth.com

Welcome, Pooja

Submit a Claim Add a Patient

Account
Users
Providers
Patients

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▼	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

First 1 2 Last

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- To view and/or edit the account information, select Account from the dropdown menu under Practice

Viewing and Editing Practice Account Information (cont)

[Provider Co-pay Portal](#) [Home](#) [Claims ▾](#) [Practice ▾](#) [Contact Us](#) [pdave@us.imshealth.com ▾](#)

Practice

TestPractice 1

NPI: 1234567891

Address

77 ABC St
Test Town, NJ 55555

Communications

Phone: (123) 555-6688
Fax: (848) 702-3045
Email: Testing@ABC.com

Payment Method

Payments are being electronically transferred to your payment account.
[Manage Electronic Payments](#)

Claim Status Updates

Receiving check payment notifications by mail.
Receiving EFT payment notifications by fax.

Manage Patients

Manage Users

Manage Providers

Edit

- The next screen will display the information about the Practice Account, including the communication method for receiving claim status updates
- The user can also use the links on the far right to navigate to Patients, Users, and Providers pages to edit and/or update records

Viewing and Editing Practice Account Information (cont)

Provider Co-pay Portal Home Claims - Practice - Contact Us

Practice

Practice Name	Practice NPI
TestPractice 1	1234567891
Street Address	
77 ABC St	
Address Line 2 (optional)	
City	
Test Town	
State	ZIP
New Jersey	55555
Phone	Email Address
(123) 555-6688	Testing@ABC.com
Remittance Address ☒ Same as practice address	

If reimbursements should be mailed to an address other than the practice address, indicate the remittance address here.

Payment Method

You can receive payment for your claims by any of the methods below. Electronic payments require additional setup on our payment provider's website.
Changes will take effect for the next claim you submit.

Claim Status Updates

Notifications for check payments are sent by direct mail to the mailing address above.
If you would like fax notifications for EFT payments, enter your fax number below.

☒ Receive EFT payment updates at this fax number:

- To edit the Practice Account information, click on “Edit” (previous page). The user can proceed to edit the information about the practice, except for the Practice NPI. Once the user has completed the edits, click on “Save”

Viewing and Editing Practice Account Information (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Practice

Practice information has been updated. ✕

TestPractice 1

NPI: 1234567891

Address

77 ABC St
Test Town, NJ 55555

Communications

Phone: (123) 555-6688
Fax: (848) 702-3045
Email: Testing@ABC.com

Payment Method

Payments are being electronically transferred to your payment account.

[Manage Electronic Payments](#)

Claim Status Updates

Receiving check payment notifications by mail.
Receiving EFT payment notifications by fax.

[Manage Patients](#)
[Manage Users](#)
[Manage Providers](#)

Edit

- A screen will display with a message confirming the updated information and will display the Practice Account information

Users

Provider Co-pay Portal

Home

Claims ▾

Practice ▾

Contact Us

pdave@us.imshealth.com ▾

Welcome, Pooja

Submit a Claim

Add a Patient

Account

Users

Providers

Patients

Need help?

Call Customer Support

(833) 277-7542

8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims

See all claims

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

First

1

2

Last

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- To view and/or edit users, select “Users” from the dropdown menu under Practice

Users (cont)

[Provider Co-pay Portal](#) [Home](#) [Claims](#) [Practice](#) [Contact Us](#) [pdave@us.imshealth.com](#)

Users

[Add a User](#)

Name	Email Address	Role	Administrator	
Test Test1	Test@Testing.com	Office/Billing Administrator	☒	Edit

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- The User's main screen will display all current users registered for the Practice Account. From this screen, new users can be added, or current users' information can be updated

Users (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Users

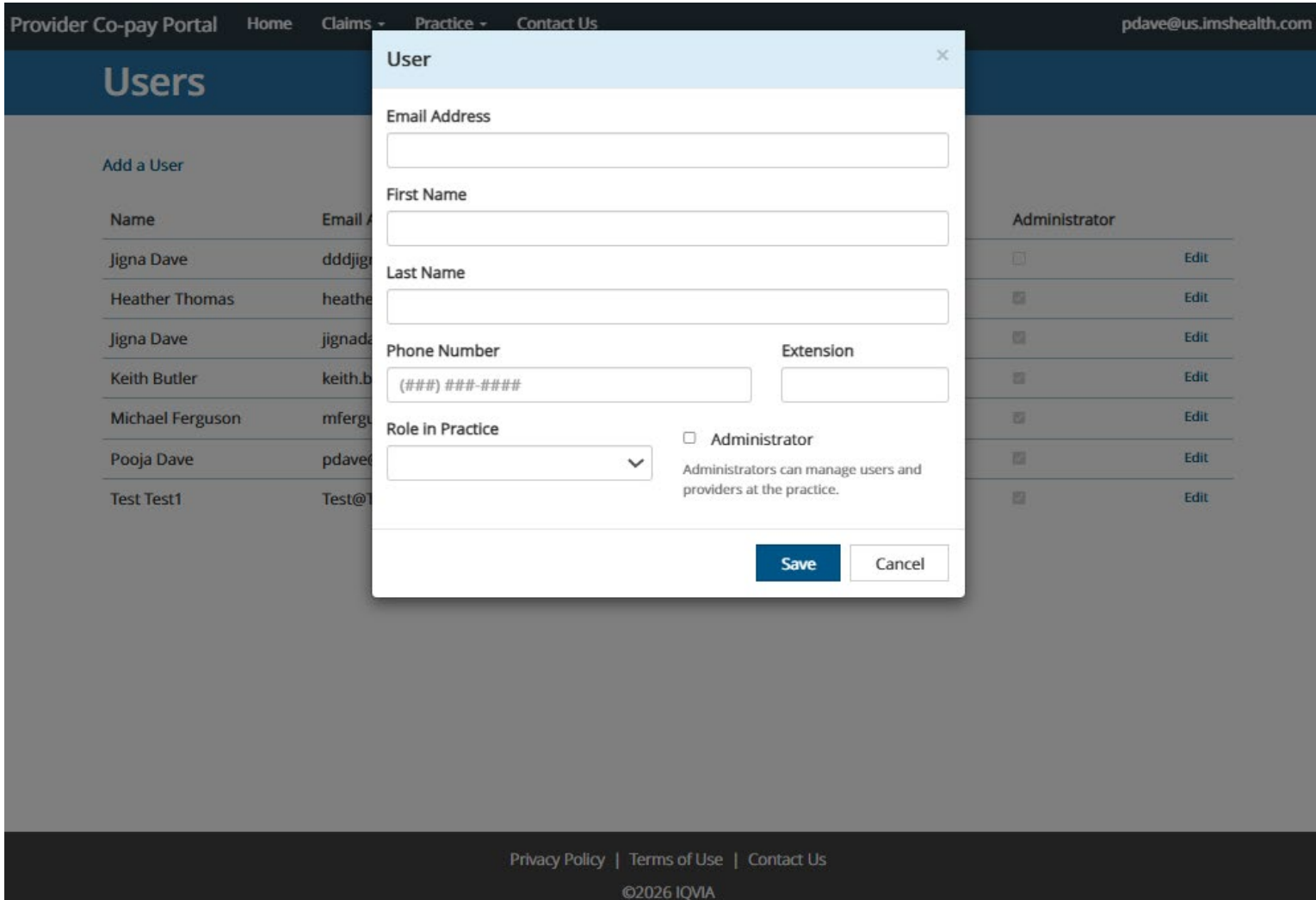
[Add a User](#)

Name	Email Address	Role	Administrator	
Test Test1	Test@Testing.com	Office/Billing Administrator	☒	Edit

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- To add a new User to the Practice Account, select the “Add a user” link from the User's main screen

Users (cont)



Provider Co-pay Portal Home Claims Practice Contact Us pdave@us.imshealth.com

Users

Add a User

Name	Email Address
Jigna Dave	dddjig
Heather Thomas	heathe
Jigna Dave	jignad
Keith Butler	keith.b
Michael Ferguson	mfergu
Pooja Dave	pdave
Test Test1	Test@T

User

Email Address

First Name

Last Name

Phone Number (###) ###-####

Extension

Role in Practice

☒ Administrator

Administrators can manage users and providers at the practice.

Save Cancel

Administrator	Edit
☐	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit

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- On the next screen, enter the User details. All fields are required except for the Extension and Administrator indicator
- If the user entered is responsible for the maintenance of the Users and Providers information for the Practice Account, ensure the box to the left of Administrator is checked
- Click on “Save.” The user’s main screen will display, and the new user will be visible. Be sure to alert all added users that they will receive an email to validate their account. This validation must be done prior to using the Provider Co-pay Portal

Users (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Users

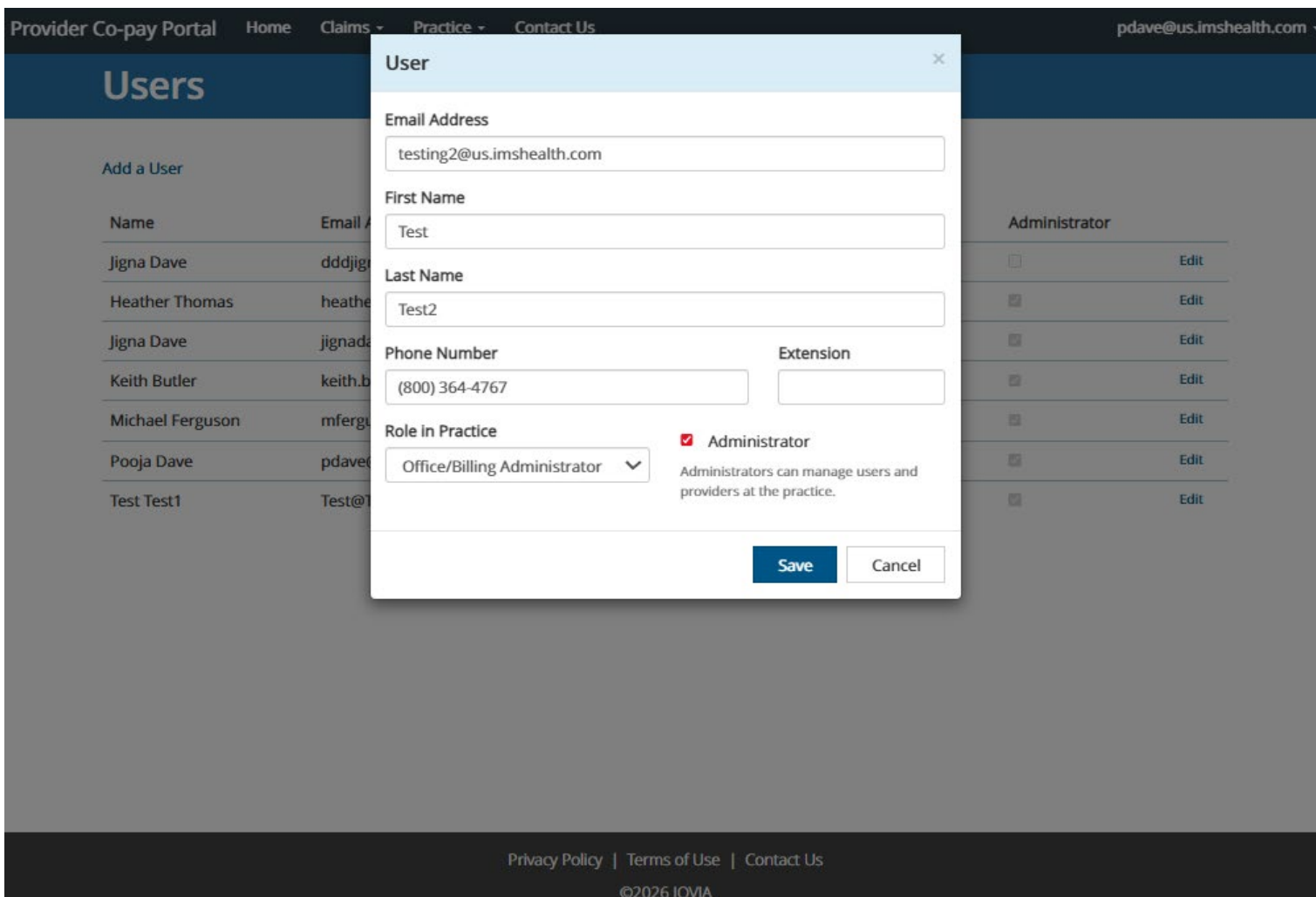
[Add a User](#)

Name	Email Address	Role	Administrator	
Test Test1	Test@Testing.com	Office/Billing Administrator	☒	Edit

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- To edit a current User's contact information, navigate to the Users main screen and click on the "Edit" link to the right of the User's name

Users (cont)



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Users

Add a User

Name	Email Address
Jigna Dave	dddjig
Heather Thomas	heathe
Jigna Dave	jignad
Keith Butler	keith.b
Michael Ferguson	mferg
Pooja Dave	pdave
Test Test1	Test@

User

Email Address
testing2@us.imshealth.com

First Name
Test

Last Name
Test2

Phone Number
(800) 364-4767

Extension

Role in Practice
Office/Billing Administrator

☒ Administrator
Administrators can manage users and providers at the practice.

Save Cancel

Administrator	Edit
☐	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit
☒	Edit

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- The next screen will display the selected User's contact information. Once the required edits are complete, click on "Save." If the incorrect User was chosen for editing, click on "Cancel." Either selection will bring the user back to the User's main screen

Providers

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Welcome, Pooja

Account
Users
Providers
Patients

Submit a Claim Add a Patient

Need help?
Call Customer Support
(833) 277-7542
8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims [See all claims](#)

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▼	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
New Claim	149658	L86100106434	BUTLER, KEITH	Dave, Pooja		4/22/2026		View
New Claim	141678	L86100108256	TEST, TEST	Watkins, Susan		2/26/2025		View
New Claim	140099	K53100114206	TESTONE, TESTONE	Ale, Vanina		9/16/2024		View
New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
New Claim	135869	L86100106434	BUTLER, KEITH	Dave, Pooja		10/13/2023		View
New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

First 1 2 Last

- To edit a current Provider's information, navigate to the Providers main screen and click on the "Edit" link to the right of the Provider's name

Providers (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Providers

[Add a Provider](#)

Name	NPI	SLN	Type	
Keith Butler	1234567891		Medical Doctor	Edit
Pooja Dave	1112123456		Medical Doctor	Edit
Susan Watkins	1376700591		Medical Doctor	Edit
Vanina Ale	1234567890	MM/DD/YYYY	Medical Doctor	Edit

- The Providers main screen will display all current providers registered for the Practice Account. From this screen, new providers can be added, or current providers' information can be updated

Providers (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Providers

Add a Provider

Name	NPI	SLN	Type	
Keith Butler	1234567891		Medical Doctor	Edit
Pooja Dave	1112123456		Medical Doctor	Edit
Susan Watkins	1376700591		Medical Doctor	Edit
Vanina Ale	1234567890	MM/DD/YYYY	Medical Doctor	Edit

- To add new Providers to the Practice Account, select the “Add a Provider” link from the Providers main screen

Providers (cont)

Provider Co-pay Portal Home Claims Practice Contact Us pdave@us.in

Providers

Add a Provider

Name	Edit
Keith Butler	Edit
Pooja Dave	Edit
Susan Watkins	Edit
Vanina Ale	Edit

Provider

First Name

Last Name

NPI Number

State License Number (optional)

Provider Type

Save

Cancel

- On the next screen, enter the Provider details in all fields and click on “Save.” The Providers main screen will display, and the new provider will be visible

Providers (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us pdave@us.imshealth.com ▾

Providers

[Add a Provider](#)

Name	NPI	SLN	Type	
Keith Butler	1234567891		Medical Doctor	Edit
Pooja Dave	1112123456		Medical Doctor	Edit
Susan Watkins	1376700591		Medical Doctor	Edit
Vanina Ale	1234567890	MM/DD/YYYY	Medical Doctor	Edit

- To edit a current Provider's information, navigate to the Providers main screen and click on the "Edit" link to the right of the Provider's name

Providers (cont)

Provider Co-pay Portal Home Claims Practice Contact Us pdave@us.imshealth.com

Providers

Add a Provider

Name	Edit
Keith Butler	Edit
Pooja Dave	Edit
Susan Watkins	Edit
Vanina Ale	Edit

Provider

First Name

test

Last Name

test

NPI Number

1234567890

State License Number (optional)

Provider Type

Medical Doctor

Save

Cancel

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- The next screen will display the selected Provider's information. Once the required edits are complete, click on "Save." If the incorrect Provider was chosen for editing, click on "Cancel." Either selection will bring the user back to the Providers main screen

Patients

Provider Co-pay Portal

Home

Claims ▾

Practice ▾

Contact Us

pdave@us.imshealth.com ▾

Welcome, Pooja

Submit a Claim

Add a Patient

Account

Users

Providers

Patients

Need help?

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8:00 AM - 8:00 PM ET Mon-Fri

Pending Claims

See all claims

Status	Confirmation #	Card ID #	Patient	Provider	Date of Service	Date Submitted ▾	Date Updated	Claim Amount
New Claim	149890	K53100114206	TESTONE, TESTONE	Dave, Pooja		5/4/2026		View
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New Claim	139110	L86100112103	TEST, TEST	Butler, Keith		5/29/2024		View
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New Claim	134991	L86100108256	TEST, TEST	Butler, Keith		8/28/2023		View
New Claim	134387	L86100106434	BUTLER, KEITH	Butler, Keith		7/25/2023		View
New Claim	132287	L86100108256	TEST, TEST	Butler, Keith		3/13/2023		View
New Claim	129932	K53100114132	TEST, TEST	Butler, Keith		11/2/2022		View

First

1

2

Last

- To enroll a patient, the user will go to the Practice tab, select "Patients" from the dropdown or select "Add a Patient"
- User can identify the patient as needing a card, or if the patient has already enrolled via another channel, they can continue by entering the card details

Patients (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us

Patients

Enter the first few letters of the patient's first and/or last name, or leave both fields empty to see all patients.

First Name Last Name

Add a Patient

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- The Patients main screen will display the search tool and the option to “Add a Patient”

Patients (cont)

Provider Co-pay Portal Home Claims ▾ Practice ▾ Contact Us

Patients

Enter the first few letters of the patient's first and/or last name, or leave both fields empty to see all patients.

First Name

Last Name

Add a Patient

- To add a new Patient to the Practice Account, select the “Add a Patient” link from the Patients main screen

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Patients (cont)

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Patient

First Name First Name is required.	Last Name Last Name is required.	Does the patient have a card? ☒ Yes ☐ No
Date of Birth MM/DD/YYYY Date of Birth is required.	Gender Gender is required.	Co-pay Card GRP # Co-pay Card GRP # is required.
Street Address Street Address is required.		Co-pay Card ID # Co-pay Card ID # is required.
Address Line 2 (optional) 		Phone (000) 000-0000 Phone is required.
City City is required.		Email Email is required.
State State is required.	ZIP ZIP is required.	Has the patient started taking LEQVIO (inclisiran) as prescribed? ☐ Yes ☐ No Response is required.
Caregiver First Name Caregiver First Name is required.	Caregiver Last Name Caregiver Last Name is required.	
Caregiver Date of Birth MM/DD/YYYY Caregiver Date of Birth is required.	☒ Address same as patient?	
Caregiver Relationship to Patient? Caregiver Relationship to Patient is required.		

Patient Consent
Choose how you would like to collect the patient's consent.

☒ **Electronic Signature**
The patient will receive an email with a link to provide consent online.

☐ **Authorization Form**
Attach the authorization form, which will be reviewed by IQVIA Program Support.

Electronic Signature
I have discussed the LEQVIO Co-pay Program 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 Co-pay Program. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.

Note: If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

Enter the fields on Patient data capture screen. All fields highlighted in red are required:

- First Name
- Last Name
- Date of Birth – Enter the patient's date of birth using two digits for month, two digits for day, and four digits for the year
- Gender – Select Female or Male from the dropdown
- Street Address – Enter the patient's primary address
- Address Line 2 – Enter additional address information if applicable
- City – Enter the patient's city aligned to the street address information entered
- State – Select the patient's state from the dropdown aligned to the street address entered
- ZIP – Enter the 5-digit ZIP code aligned to the street address entered

Patients (cont)

Enter the caregiver details on the Patient Data Capture screen. All fields highlighted in red are required:

- Caregiver First & Last Name
- Caregiver Date of Birth (MM/DD/YYYY)
- Caregiver Relationship to Patient – Required
- Address Same as Patient – Select if applicable

Caregiver Relationship to Patient?

Parent
Legal Guardian
Other

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Patient

First Name Last Name
First Name is required. Last Name is required.

Date of Birth Gender
Date of Birth is required. Gender is required.

Street Address
Street Address is required.

Address Line 2 (optional)

City
City is required.

State ZIP
State is required. ZIP is required.

Caregiver First Name Caregiver Last Name
Caregiver First Name is required. Caregiver Last Name is required.

Caregiver Date of Birth ☒ Address same as patient?
Caregiver Date of Birth is required.

Caregiver Relationship to Patient?
Caregiver Relationship to Patient is required.

Does the patient have a card?
☒ Yes ☐ No

Co-pay Card GRP #
Co-pay Card GRP # is required.

Co-pay Card ID #
Co-pay Card ID # is required.

Phone ☒ Home ☐ Mobile
Phone is required.

Email
Email is required.

Has the patient started taking LEQVIO (inclisiran) as prescribed?
☐ Yes ☐ No
Response is required.

Electronic Signature
The patient will receive an email with a link to provide consent online.

Authorization Form
Attach the authorization form, which will be reviewed by IQVIA Program Support.

Electronic Signature
I have discussed the LEQVIO Co-pay Program with my patient, who has authorized me under HIPAA and state law to disclose their information to Neuros for the limited purpose of enrolling in the LEQVIO Co-pay Program. To complete this enrollment, Neuros may contact the patient by phone, text, and/or email.

Note: If we are unable to validate patient authorization within 30 days, this record will be removed from the system.

Patients (cont)

Patient

First Name	Last Name
Date of Birth	Gender
MM/DD/YYYY	v
Street Address	
Address Line 2 (optional)	
City	
State	ZIP
v	#####

Patient Consent

Choose how you would like to collect the patient's consent.

☒ **Electronic Signature**

The patient will receive an email with a link to provide consent online.

☐ **Authorization Form**

Attach the authorization form, which will be reviewed by IQVIA Program Support.

Electronic Signature

I have discussed the LEQVIO Co-pay Program 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 Co-pay Program. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.

Note: If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

Save

Cancel

Does the patient have a card?

☒ Yes ☐ No

Co-pay Card GRP #

Co-pay Card ID #

Phone ☒ Home ☐ Mobile

Email

Has the patient started taking LEQVIO (Inclisiran) as prescribed?

☐ Yes ☐ No

- If the patient does not yet have a co-pay card, select "No" and one will be generated after clicking "Save"
- If the patient does have a co-pay card, select "Yes" and complete these fields:
 - Co-pay Card GRP # - Enter the group number from the patient's co-pay card. This is a 9-character alpha-numeric value beginning with OH or a 10-character alpha-numeric value beginning with EC
 - Co-pay Card ID # - Enter the 12-digit ID# from the patient's co-pay card
 - Phone - Enter the patient's 10-digit phone number and select the appropriate radio button to indicate if it is a Home or Mobile number
 - Email - Enter the patient's email address

Patients (cont)

Patient Consent

Choose how you would like to collect the patient's consent.

☐ Electronic Signature
The patient will receive an email with a link to provide consent online.

☒ Authorization Form
Attach the authorization form, which will be reviewed by IQVIA Program Support.

Authorization Form

Download form

⬆ Attach Form

By attaching this form, I attest the patient authorization form is complete and accurate. I understand that this form will be verified within 2 business days, after which I will be able to submit claims for reimbursement.

Note: If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

- There are 2 options available to capture Patient Consent: Electronic Signature and the standalone Authorization Form
- **Authorization Form** – Each patient must complete and sign a Co-pay Authorization Form before their record can be saved. Download and print the form using the “Download Form” link, assist the patient with completion, and upload the signed form to the patient record by selecting “Attach Form” and choosing the appropriate file from the computer then clicking “Open”
- **Note:** The document must be in one of the following formats: picture file (jpg, jpeg, gif, png, bmp, tif, tiff) or PDF
- If the wrong document is selected, the user may remove it from the record before saving by clicking on the red “x” next to the document name

The standalone Authorization Form can be accessed [here](#)

Patients (cont)

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Patient

✔ Patient has been added. ✕

This patient has not yet provided consent.
If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

Name	Co-pay Card GRP #	Co-pay Card ID #
TEST10 TEST	OH7142071	L86100117840
Date of Birth	Gender	
05/06/2012	Female	
Address	Home Phone	
10 HIGH STREET MONROE, FL 88888	(888) 888-8888	
	Email	
	PDAVE@US.IMSHEALTH.COM	
	Has the patient started taking LEQVIO (inclisiran) as prescribed?	
	☒ Yes ☐ No	
Caregiver/Legal Guardian Name	Caregiver/Legal Guardian Address	
Test Test	Same as patient	
Caregiver/Legal Guardian Date of Birth		
05/24/1991		
Caregiver Relationship to Patient		
PARENT		
Electronic Signature		
⚠ Awaiting online consent		
Resend email		
Edit	Close	

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- This screen will display the patient record details. Once the Authorization Form is approved, the user may Submit a Claim, Edit the patient record, or Close the record

Patients (cont)

Patient Consent

Choose how you would like to collect the patient's consent.

☒ **Electronic Signature**

The patient will receive an email with a link to provide consent online.

☐ **Authorization Form**

Attach the authorization form, which will be reviewed by IQVIA Program Support.

Electronic Signature

I have discussed the LEQVIO Co-pay Program 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 Co-pay Program. To complete this enrollment, Novartis may contact the patient by phone, text, and/or email.

Note: If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

- **Electronic Signature** – Each patient must complete their HIPAA consent and their consent to participate in the Co-pay Program. The Electronic Signature option allows patients to complete this process online via a link that will be emailed to them after the completion of the Co-pay Portal enrollment by the provider
- **Note:** A patient email address is a required field for enrollment in the Co-pay Program

Email

Email is required.

Patients (cont)

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Patient

Patient information has been updated.

This patient has not yet provided consent.

If we are unable to validate patient authorization within 20 days, this record will be removed from the system.

Name	Co-pay Card GRP #	Co-pay Card ID #
TEST10 TEST	OH7142071	L86100117840
Date of Birth	Gender	
05/06/2012	Female	
Address	Home Phone	
10 HIGH STREET MONROE, FL 88888	(888) 888-8888	
	Email	
	PDAVE@US.IMSHEALTH.COM	
	Has the patient started taking LEQVIO (inclisiran) as prescribed?	
	☒ Yes ☐ No	
Caregiver/Legal Guardian Name	Caregiver/Legal Guardian Address	
Test Test	Same as patient	
Caregiver/Legal Guardian Date of Birth		
05/24/1991		
Caregiver Relationship to Patient		
PARENT		
Electronic Signature		
 Awaiting online consent		
 Resend email		

Edit

Close

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- This screen will display the patient record details. Once the Electronic Signature is completed, the user may Submit a Claim, Edit the patient record, or Close the record
- For patients using Electronic Signature, providers have an option to resend the Electronic Signature email to patients if they are reporting they have not received the initial email with the link to the Microsite

Patients (cont)



From: donotreply@opushealth.com <donotreply@opushealth.com>

Sent: Wednesday, May 6, 2026 8:45 AM

To: ● Dave, Pooja

Subject: Novartis Patient Support Program - Complete Your Co-pay Enrollment

Hello,

Novartis Patient Services is following up on a recent request from you and your doctor to help you get the medicine you were prescribed. We need you to complete your patient authorization form for co-pay program enrollment. Please click the link below to do so.

<https://uat.opushealth.com/eSignatureMicrosite/Consent/Verify?pid=qwnkeFPld2qPrW18bA7XUQ-&configCode=INCL>

If you have questions, please call co-pay program support at (833) 277-7542.

Thank you,
Program Support

Please do not reply to this message, which was sent from an unmonitored email address.

- Once the patient enrollment process is completed by the provider for the Electronic Signature option, the patient will receive an email at the email address they provided, which will contain a link for the patient to access the Microsite and complete their HIPAA Consent and Patient Authorization Consent

Patients (cont)

eSignature Microsite

We need to verify your identity

Please provide information below and click "Verify" button to proceed.

Last Name

Date of Birth (MM/DD/YYYY)

☐

I'm not a robot



Verify

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- When the patient clicks the link in the email, they will be taken to a security verification page in which they will need to provide their last name and date of birth in order to move forward
- Once the patient has entered the required information, they will check the reCAPTCHA check box and click "Verify" to be taken to the Electronic Signature Microsite
- Within the Electronic Signature Microsite, patient will be asked to provide their electronic signature and attest that they read and agree to the LEQVIO Co-pay Program terms & conditions.

Contact Us



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Contact Us

Please feel free to contact us with any questions or issues regarding your account.

Customer Support

(833) 277-7542

8:00 AM - 8:00 PM ET Mon-Fri

- If the user has a question that cannot be addressed in this guide, please use the following information for assistance. This information is available on most pages throughout the portal and on the Contact Us screen

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Thank you for using the LEQVIO® (inclisiran) Provider Co-pay Portal

You can now:

- Help a patient enroll and obtain a co-pay card for manual medical claims adjudication
- View patient claims activity and benefit amount
- Add/edit patient demographic information
- Add/edit patient insurance information
- Submit a medical claim to IQVIA for claims adjudication

Remember to bookmark the portal for future use:

<https://hccopayportal.opushealth.com>

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