LEQVIO® Free Trial Offer (FTO) Order Form

LEQVIO (inclisiran) injection 284 mg/1.5 mL

Phone: 1-888-590-2089 **Fax:** 1-833-352-0460

This form is required to provide a prescription for patients to receive a LEQVIO Free Trial Offer. By completing and submitting this form, you agree to the following terms and conditions:

No purchase required. Eligible patients must be new to therapy. Eligible patients may not receive more than one dose under the program. The free trial offer is not health insurance. Void where prohibited by law. Product dispensed pursuant to terms and conditions of the FTO Program. Claims shall not be submitted to any public or private third-party payer or any health care program for reimbursement. It is illegal for any person to sell, purchase, or trade, or offer to sell, purchase or trade, or to counterfeit the FTO Order Form. This is the property of Novartis Pharmaceuticals Corporation and must be returned upon request. Novartis Pharmaceuticals Corporation reserves the right to rescind, revoke, or amend the offer without notice. This Free Trial Offer expires on or before December 31, 2022.

* = REQUIRED FIELDS

* Patient Name: _____ Date of Birth: _____
First Name Middle Initial Last Name

PRESCRIPTION INFORMATION: LEQVIO® (inclisiran)

* Dosage: ☐ Prefilled syringe containing 284 mg/1.5 mL Qty: 1

Directions: Administered by a health care professional as a subcutaneous injection

Refill(s) Authorized: 0

* Prescriber Name: _____ Practice Name: _____

Address: _____

NPI #: _____ Direct Phone Line and Extension: _____

Fax: _____ Office Contact Name: _____

Office Contact Email Address: _____

PROVIDER SIGNATURE

I certify the above therapy is medically necessary, and this information is accurate to the best of my knowledge. I certify that I am the provider who has prescribed LEQVIO to the previously identified patient. I understand that I am receiving this product free of charge and that no claims for the free goods or related services are intended to be submitted to any public or private third-party payer or any health care program for reimbursement. I further understand these free goods are intended only for the patient named on this form and will not be offered for sale, trade, or barter.

* _____ _____/_____/_____
Provider Signature Date of Signature (MM/DD/YYYY)

If your state requires electronic prescribing (E-Rx), please submit electronic prescription to AllCare Plus Pharmacy NPI #1902167596.

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080