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.

At the LEQVIO Service Center, we provide access and reimbursement support to your patients who have been prescribed LEQVIO.

PATIENT ENROLLMENT—SIMPLIFIED TO MEET YOUR NEEDS.

We know patient program enrollment can be time-consuming and confusing. That's why we've created a simple one-page Start Form. Once the Start Form is completed, a dedicated Access Specialist will provide customized support based on your practice's needs.

Download and complete a paper copy or print an editable PDF and fax it to 877-537-8468.

Remember, it's important to capture the following information to ensure successful enrollment into the program:

- The patient's signature
- Prescriber's certification
- Appropriate insurance information
- The primary ICD-10-CM diagnosis code and an attestation that the patient has been diagnosed with ASCVD and/or HeFH

WHAT HAPPENS NEXT?

A dedicated Access Specialist will check the patient's insurance coverage for LEQVIO, identify any initial coverage requirements, and assess eligibility for financial assistance

You will receive updates every step of the way, and we will work with your office based on your communication preferences

Once your patient starts treatment, they will have access to support including a Welcome Kit and a dedicated Patient Care Specialist to answer any questions

NOVARTIS

LEQVIO® Service Center Start Form

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Phone: 833-LEQVIO2 **Fax:** 877-537-8468 (877-LEQVIO8) **Service Center Portal:** ServiceCenterPortal.com

Please complete this page in its entirety for the services listed below.

- Insurance Determination & Coverage Review (includes Benefits Verification, Prior Authorization Research & Appeals Support)
- Co-pay Enrollment (commercial patients only)
- Novartis Patient Assistance Foundation (NPAF) referral for eligibility check

PATIENT INFORMATION

First Name: _____ Last Name: _____ Email: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ Home Phone: _____ Cell Phone: _____

OK to leave voicemail on: ☐ Home Phone ☐ Cell Phone Preferred Language: ☐ English ☐ Spanish Other: _____

Address: _____ City: _____ State: _____ ZIP Code: _____

PATIENT AUTHORIZATION & ADDITIONAL CONSENTS (patients may visit www.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 Card Program

☐ I have read and agree to the Co-pay Card Program terms & conditions on page 3.

Ongoing Support from the LEQVIO Care Program

☐ I would like to enroll in phone support from LEQVIO Care—an optional program to help you stay on track with your treatment plan, including your own dedicated Patient Care Specialist to provide medication reminders, healthy living tips and tools. By checking the box, I agree to receive calls and texts at the phone number provided. I understand calls and texts may be autodialed or prerecorded and are not a condition of purchase.*

Determine Financial Eligibility

Novartis Patient Assistance Foundation, Inc. (NPAF) provides free LEQVIO to eligible uninsured and underinsured patients. Proof of income is required. If you choose to apply for free LEQVIO, checking the box below will prompt NPAF to verify your income.

☐ I have read and agree to the Fair Credit Reporting Act (FCRA) authorization on page 3.

INSURANCE INFORMATION (Please include a copy of both sides of the patient's medical and prescription insurance cards)

Does the patient have insurance through (please check all that apply)? ☐ Medicare Part B (Medical) ☐ Medicare Part D (Prescription)
☐ Medicare Advantage ☐ Medicaid ☐ VA/Military ☐ Commercial/Private Insurance ☐ No insurance ☐ Other: _____

	Insurance Name	Member ID/Policy #	Phone Number	Grp # / Bin # / PCN #
Primary Insurance				
Secondary Insurance				
Prescription Insurance				
Other Insurance				

PROVIDER INFORMATION

Provider Name: _____ Practice Name: _____

Practice NPI #: _____ Provider NPI #: _____ Tax ID #: _____

Primary Office Contact: _____ Office Contact Phone: _____ Ext: _____ Office Fax: _____

Address: _____ City: _____ State: _____ ZIP Code: _____ Office Phone: _____

How will the product be acquired & administered?

☐ I am going to acquire through buy-and-bill and administer in my office

☐ I am going to acquire through specialty pharmacy and administer in my office

If you intend to refer your patients to another site to receive LEQVIO, call us first before completing this form so we can provide guidance on the process. You may also visit our locator tool at LEQVIO-locator.com to find a center.

CLINICAL INFORMATION

Treatment Start Date: _____

☐ Patient was previously enrolled in an inclisiran clinical trial

ICD-10-CM Primary Diagnosis Code:

☐ E78.0 Pure Hypercholesterolemia (including HeFH)

☐ E78.2 Mixed Hyperlipidemia ☐ E78.4 Other Hyperlipidemia

☐ E78.5 Hyperlipidemia, Unspecified ☐ Other: _____

Has patient been diagnosed with ASCVD and/or HeFH, is currently receiving maximally tolerated statin therapy (or has been determined clinically intolerant), and has not reached LDL-C target (<70 mg/dL)?

☐ Yes ☐ No

ICD-10-CM Secondary Diagnosis Code: _____

PRESCRIBER CERTIFICATION

☐ I certify that the above therapy is medically necessary, and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed LEQVIO to the previously identified patient or a physician's designee, and that I provided the patient with a description of the LEQVIO Service Center. I agree to the NPAF Authorization on page 3. I also agree to receive communications, including faxes, related to my patient's enrollment or participation in the LEQVIO Service Center.

Can we contact the patient if they have issues with enrollment

☐ Yes, and I certify that I have obtained written HIPAA authorization from the patient to disclose the information on this form to Novartis Pharmaceuticals Corporation, its affiliates and service providers (NPC) to facilitate enrollment in this program, including contacting the patient.

_____ / _____ / _____ Date (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.

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, with a per treatment benefit maximum of $1,400 and an annual benefit limit of $2,000. 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.

Fair Credit Reporting Act (FCRA) Authorization
I understand that I am providing "written instructions" that authorize NPAF and its vendor, under the FCRA, to obtain information from my credit profile or other information from the vendor, solely for the purpose of determining financial qualifications for programs administered by NPAF. I understand that I must affirmatively agree to these terms in order to proceed with this financial screening process.

Novartis Patient Assistance Foundation (NPAF) Authorization FOR PHYSICIAN
I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge. I certify that I am the physician who has prescribed the drug identified above to the previously identified patient. I certify that any medication received will be used only for the patient named on this form and will not be offered for sale, trade, or barter. Further, no claim for reimbursement will be submitted concerning this medication, nor will any medication be returned for credit. I acknowledge that NPAF is exclusively for purposes of patient care and not for remuneration of any sort. I understand that NPAF may revise, change, or terminate programs at any time.

*The LEQVIO Service Center 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.

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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