LEQVIO® Co-pay Claim Request Form

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

Pick **only one** checkbox option below.

☐ I am a patient filling out the form to get money back **OR** ☐ I am a patient filling out the form to have my payment go right to my doctor

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

☐ 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 it to the LEQVIO Co-pay Program to see if your patient is eligible for co-pay support.

For patients

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, 77 Corporate Dr, Bridgewater, NJ 08807** or fax this form to **1-908-548-9364**
4. Send all required information (*see below*) to the LEQVIO Co-pay Program with this form

Patient information

* = REQUIRED FIELDS

* Patient first name: _____ * Patient last name: _____
* ZIP Code: _____ * Date of birth: _____ ☐ Male ☐ Female ☐ Other
* Patient group number: _____ (ie, EX00000000, from the LEQVIO Co-pay ID card on the Welcome Letter)
* Patient member ID number: _____ (11-digit ID from the LEQVIO Co-pay ID card on the Welcome Letter)

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
- 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
77 Corporate Dr
Bridgewater, NJ 08807

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):** _____ * **Date:** _____

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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: _____

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 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 • J-code or drug name • Date of service

If the above is not included in the EOB, please additionally submit a copy of the 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):** _____ * **Date:** _____

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Send all information needed to:

Mail to:

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77 Corporate Dr
Bridgewater, NJ 08807

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, with a per-treatment benefit maximum of $3,000 and an annual benefit limit of $3,600. 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.

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