LEQVIO® (inclisiran) Order/ Referral Form

GAMMA THERAPEUTIC CENTER
Center for Neurological Disorders

10750 W. Howard Avenue
Greenfield, WI 53228
Phone: (414) 460-3195
Fax: (414) 763-0063
www.gtinfusions.com

Patient Information	
Patient Name:	Patient DOB:

Referral Status

☐ New Referral ☐ Restart/Continuation ☐ Medication/Order Change ☐ D/C

Diagnosis and ICD 10 Code	
☐ Heterozygous Familial Hypercholesterolemia (HeFH)	ICD 10 Code: E78.01
☐ Other Diagnosis:	ICD 10 Code:
☐ Other Diagnosis:	ICD 10 Code:

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**

Supporting Documentation	
☐ Patient demographics	☐ Clinical/Progress notes supporting primary diagnosis
☐ Copy of patient insurance card(s) – front & back	☐ Labs and tests supporting diagnosis code
☐ Tried and Failed therapies	☐ Current Medication List

Medication Orders

☐ Initial Dosing: Leqvio® (inclisiran) 248mg subQ injection at 0 and 3 months

☐ Maintenance Dosing: Leqvio® (inclisiran) 248mg subQ injection every 6 months

Notes (Additional Info)

Premedication, adverse and anaphylactic reactions and post injection will be treated per Gamma Therapeutic Center protocol.

Prescriber Information

Prescriber Name:		NPI #:
Office Contact:	Office Phone:	Office Fax:
Prescriber Signature:		Date: (Order is valid for one year)

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Gamma Therapeutic Center and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Notify patient we will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.

LEQVIO® Patient Authorization and Additional Consents

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

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

PATIENT INFORMATION – FORM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

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

ZIP: _____ Email (recommended to enroll in co-pay support): _____

PATIENT AUTHORIZATION & ADDITIONAL CONSENTS

I have read and agree to the Patient Authorization on page 2.

_____ ____/____/_____
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 2.

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 2.

For questions, please call: **833-LEQVIO2**.

Once completed, fax just this page to **877-537-8468 (877-LEQVIO8)**.

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NOVARTIS

LEQVIO® Patient Authorization and Additional Consents

LEQVIO® (inclisiran) injection 284 mg/1.5 mL

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.

*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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