Leqvio® (inclisiran) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: start date ____/____/____ ☐ Continuation of therapy, date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Cardiologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Leqvio (inclisiran) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ **Secondary ICD Code:** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the current LDL-C level in mg/dL: _____

For Initiation Requests (clinical documentation required):

☐ Yes ☐ No Will the patient continue to receive concomitant statin therapy?
→ ☐ Yes ☐ No Does the patient have intolerance or contraindication to high-intensity statin therapy?

Please indicate the prior therapy the patient has previously received (select all that applies to the patient):

☐ The patient is receiving a high-intensity statin dose daily, such as rosuvastatin (Crestor) 20 mg daily or atorvastatin (Lipitor) 40 mg daily
→ Please indicate the start date: ____/____/____
☐ Yes ☐ No Has the patient received this dose for at least 3 months?
→ ☐ Yes ☐ No Was the patient unable to tolerate a high-intensity statin due to adverse effects?

☐ The patient is receiving a moderate-intensity statin dose daily, such as atorvastatin (Lipitor) 20 mg or equivalent
→ Please indicate the start date: ____/____/____
☐ Yes ☐ No Has the patient received this dose for at least 3 months?

☐ The patient has intolerance to a high-intensity statin therapy
→ ☐ Yes ☐ No Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI)?
☐ Yes ☐ No Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin?

☐ The patient has contraindication to a high-intensity statin therapy
→ Please indicate which of the following applies to the patient:
☐ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., ALT greater than or equal to 3 times the upper limit of normal)
☐ Currently pregnant
☐ Planning pregnancy
☐ Breastfeeding
☐ None of the above

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Clinical atherosclerotic cardiovascular disease (ASCVD)

Please indicate which of the following manifestations of clinical atherosclerotic cardiovascular disease (ASCVD) the patient has experienced:

- ☐ Acute coronary syndrome
- ☐ Coronary Artery Calcium (CAC) score of greater than or equal to 1000
- ☐ Coronary or other arterial revascularization procedure (e.g., percutaneous coronary intervention [PCI], coronary artery bypass graft [CABG] surgery)
- ☐ Myocardial infarction
- ☐ Non-cardiac peripheral arterial disease (PAD) of presumed atherosclerotic origin (e.g., carotid artery stenosis, lower extremity PAD)
- ☐ Obstructive coronary artery disease (defined as fifty percent or greater stenosis on cardiac computed tomography angiogram or catheterization)
- ☐ Stable or unstable angina
- ☐ Stroke of presumed atherosclerotic origin
- ☐ Transient ischemic attack (TIA)
- ☐ Other

Heterozygous familial hypercholesterolemia (HeFH)

☐ Yes ☐ No Does the patient possess an LDL-receptor mutation, familial defective apo B-100 or a PCSK9 mutation?

→ Please indicate the patient's untreated (before any lipid-lowering therapy) LDL-C level in mg/dL: _____

Please select which of the following applies to the patient:

- ☐ Family history of myocardial infarction (MI) at less than 60 years of age in a first degree relative or less than 50 years of age in a second degree relative
- ☐ Family history of total cholesterol (TC) greater than 290 mg/dL in a first/second degree relative
- ☐ Presence of tendon xanthoma(s) in the patient or first/second-degree relative
- ☐ None of the above- the patient does not meet any of the criteria listed above

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Has the patient achieved or maintained an LDL-C reduction (e.g., LDL-C is now at goal, robust lowering of LDL-C) as the result of the requested medication therapy?

Please indicate which of the following applies to the patient:

☐ The patient is currently receiving concomitant statin therapy

→ ☐ Yes ☐ No Will the patient continue to receive concomitant statin therapy?

☐ The patient has intolerance to a high-intensity statin therapy

→ ☐ Yes ☐ No Did the patient score a 7 or higher on the Statin-Associated Muscle Symptom Clinical Index (SAMS-CI)?

☐ Yes ☐ No Did the patient experience a statin-associated increase in creatine kinase (CK) level of greater than or equal to 10 times the upper limit of normal (ULN) during previous treatment with a statin?

☐ The patient has contraindication to a high-intensity statin therapy

→ Please indicate which of the following applies to the patient:

- ☐ Active liver disease, including unexplained persistent elevations in hepatic transaminase levels (e.g., ALT greater than or equal to 3 times upper limit of normal)
- ☐ Currently pregnant
- ☐ Planning pregnancy
- ☐ Breastfeeding
- ☐ None of the above

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.