aetna®

MEDICARE FORM

Leqvio® (inclisiran) Medication Precertification Request

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

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

For other lines of business:
Please use other form.

Note: For MAPD plans, Leqvio is non-preferred. Praluent is preferred through the Part D benefit. Repatha is also preferred for MAPD plans with open formularies. Leqvio is not subject to step therapy on MA only plans.

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: _____
NPI: _____

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

E. PRODUCT INFORMATION

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

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):

Note: Leqvio is non-preferred on MAPD plans. Praluent is preferred through the Part D benefit. Repatha is also preferred for MAPD plans with open formularies. Leqvio is not subject to step therapy on MA only plans.

☐ Yes ☐ No Has the patient had prior therapy with Leqvio (inclisiran) within the last 365 days?

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Praluent (alirocumab) ☐ Repatha (evolocumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Praluent (alirocumab) ☐ Repatha (evolocumab)

_____

☐ 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?

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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.

For Initiation Requests (clinical documentation required) - *continued*:

☐ 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

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.