Fax completed form to: (855) 840-1678
If this is an URGENT request, please call
(800) 882-4462 (800.88.CIGNA)

Leqvio
(inclisiran)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Leqvio 284 mg/1.5 mL syringe ☐ other (please specify):

ICD10:

Directions for use: Quantity:

Where will this medication be obtained?
☐ Physician's office stock
☐ Retail Pharmacy:
☐ Home Health / Home Infusion vendor (name):
CPT Code(s):
☐ Other *(please specify)*:

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):
Is the requested medication for a chronic or long –term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is the patient's diagnosis or reason for treatment?
PLEASE NOTE: A patient may have a diagnosis that pertains to more than one indication, therefore, consider review under different approval conditions, if applicable (for example, a patient with heterozygous familial hypercholesterolemia may have established cardiovascular disease, a patient with primary hyperlipidemia may have heterozygous familial hypercholesterolemia).

☐ Established Cardiovascular Disease
☐ Heterozygous Familial Hypercholesterolemia (HeFH)
☐ Primary Hyperlipidemia (combined hyperlipidemia, hypercholesterolemia (pure, primary), dyslipidemia, or increased/elevated low-density lipoprotein cholesterol (LDL-C) levels)
☐ other

(if other) Please provide the patient's diagnosis or reason for treatment.

Clinical Information:

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Leqvio after approval through the Coverage Review Department for this specific indication?
☐ Initial therapy
☐ Currently receiving Leqvio after approval through the Coverage Review Department for this specific indication
☐ Restarting therapy with Leqvio
☐ None of the above

(if Currently receiving Leqvi) Has the patient experienced a response to therapy? Note: Examples of a response to therapy include decreasing LDL-C, total cholesterol, non-high-density lipoprotein (non-HDL-C), or apolipoprotein B levels.
☐ Yes ☐ No

(if no) Please provide support for continued use.

(if Established Cardiovascular Disease) Is there documentation that your patient has one of the following conditions or diagnoses?
☐ A previous myocardial infarction (MI) or a history of an acute coronary syndrome (ACS)
☐ Angina (stable or unstable)
☐ A past history of stroke or transient ischemic attack (TIA)
☐ Coronary artery disease (CAD)
☐ Peripheral arterial disease (PAD)
☐ Has undergone a coronary or other arterial revascularization procedure in the past (for example, coronary artery bypass graft surgery, percutaneous coronary intervention, angioplasty, or coronary stent procedures)
☐ None of the above

(if Established Cardiovascular Disease) Has the patient tried ONE high-intensity statin therapy (that is, atorvastatin 40 mg daily or higher; rosuvastatin 20 mg daily or higher [as a single entity or as a combination product])? ☐ Yes ☐ No

(if yes) Did the patient try the high-intensity statin therapy along with ezetimibe (as a single-entity or as a combination product) for at least 8 continuous weeks? ☐ Yes ☐ No

(if yes) After receiving this therapy, was the patient's low-density lipoprotein cholesterol (LDL-C) level of at least 55 mg/dL? ☐ Yes ☐ No

(if no) Did your patient experience statin-related rhabdomyolysis? Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage, which can include signs of acute renal injury (noted by substantial increases in serum creatinine [SCr] levels [a 0.5 mg/dL or greater increase in SCr or doubling of the SCr] and/or myoglobinuria [myoglobin present in urine]). ☐ Yes ☐ No

(if no) Did your patient experience skeletal-related muscle symptoms? Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness).
☐ Yes ☐ No

(if yes) Did the skeletal-muscle related symptoms occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product)? ☐ Yes ☐ No

(if yes) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), did the skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin)? Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia. ☐ Yes ☐ No

(if HeFH) Is there documentation that one of the following was used to confirm the diagnosis in your patient?
☐ Dutch Lipid Network clinical criteria, score greater than 5
☐ Genetic confirmation of HeFH: pathogenic variants at the low-density lipoprotein receptor (LDLR), apolipoprotein B (apo B), proprotein convertase subtilisin kexin type 9 (PCSK9), or low-density lipoprotein receptor adaptor protein 1 (LDLRAP1) gene
☐ Simon-Broome criteria threshold met for 'definite' or 'possible (or probable)' familial hypercholesterolemia
☐ an untreated LDL-C of at least 190 mg/dL (prior to treatment with antihyperlipidemic agents)
☐ None of the above

(if HeFH) Has the patient tried ONE high-intensity statin therapy (that is, atorvastatin 40 mg daily or higher; rosuvastatin 20 mg daily or higher [as a single entity or as a combination product])? ☐ Yes ☐ No

(if yes) Did the patient try the high-intensity statin therapy along with ezetimibe (as a single-entity or as a combination product) for at least 8 continuous weeks? ☐ Yes ☐ No

(if yes) After receiving this therapy, was the patient's low-density lipoprotein cholesterol (LDL-C) level of at least 70 mg/dL? ☐ Yes ☐ No

(if no) Did your patient experience statin-related rhabdomyolysis? Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage, which can include signs of acute renal injury (noted by substantial increases in serum creatinine [SCr] levels [a 0.5 mg/dL or greater increase in SCr or doubling of the SCr] and/or myoglobinuria [myoglobin present in urine]). ☐ Yes ☐ No

(if no) Did your patient experience skeletal-related muscle symptoms? Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness). ☐ Yes ☐ No

(if yes) Did the skeletal-muscle related symptoms occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product)? ☐ Yes ☐ No

(if yes) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), did the skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin)? Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia. ☐ Yes ☐ No

(if Primary Hyperlipidemia) Does the patient have a coronary artery calcium or calcification score at least 300 Agatston units? ☐ Yes ☐ No

(if no) Does the patient have diabetes? ☐ Yes ☐ No

(if Primary Hyperlipidemia) Has the patient tried ONE high-intensity statin therapy (that is, atorvastatin 40 mg daily or higher; rosuvastatin 20 mg daily or higher [as a single entity or as a combination product])? ☐ Yes ☐ No

(if yes) Did the patient try the high-intensity statin therapy along with ezetimibe (as a single-entity or as a combination product) for at least 8 continuous weeks? ☐ Yes ☐ No

(if yes) After receiving this therapy, was the patient's low-density lipoprotein cholesterol (LDL-C) level of at least 70 mg/dL? ☐ Yes ☐ No

(if no) Did your patient experience statin-related rhabdomyolysis? Note: Rhabdomyolysis is statin-induced muscle breakdown that is associated with markedly elevated creatine kinase levels (at least 10 times the upper limit of normal), along with evidence of end organ damage, which can include signs of acute renal injury (noted by substantial increases in serum creatinine [SCr] levels [a 0.5 mg/dL or greater increase in SCr or doubling of the SCr] and/or myoglobinuria [myoglobin present in urine]). ☐ Yes ☐ No

(if no) Did your patient experience skeletal-related muscle symptoms? Note: Examples of skeletal-related muscle symptoms include myopathy (muscle weakness) or myalgia (muscle aches, soreness, stiffness, or tenderness). ☐ Yes ☐ No

(if yes) Did the skeletal-muscle related symptoms occur while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or combination product)? ☐ Yes ☐ No

(if yes) When receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination product), did the skeletal-related muscle symptoms resolve upon discontinuation of each respective statin therapy (atorvastatin and rosuvastatin)? Note: Examples of skeletal-related muscle symptoms include myopathy and myalgia. ☐ Yes ☐ No

(if initial) The covered alternative is Repatha (evolocumab subcutaneous injection) [may require prior authorization]. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if initial) Per the information provided above, which of the following is true for your patient in regard to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough
☐ The patient tried the alternative, but they did not tolerate it
☐ Other

While receiving Leqvio, will your patient also be treated with Repatha (evolocumab subcutaneous injection) or Praluent (alirocumab subcutaneous injection)? ☐ Yes ☐ No

(if yes or unknown) Please provide the rationale for concurrent use.

Additional Pertinent Information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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