Montana Healthcare Programs Prior Authorization Request Form for Use of Leqvio® (inclisiran)

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<th>Member Name:</th>
<th>DOB:</th>
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<th>Member ID:</th>
<th>Prescriber Phone:</th>
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<tr>
<th>Prescriber Name/Specialty (if applicable):</th>
<th>Prescriber Fax:</th>
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Requested Drug/Dose/Directions:

Please complete below information for applicable situation, **Initiation** or **Continuation** of therapy:

☐ **INITIATION OF THERAPY**

1. Member is 18 years of age or older: ☐ Yes ☐ No

2. Member must have appropriate FDA-approved indication for medication (please check):
   - ☐ Heterozygous familial hypercholesterolemia (HeFH)
   - ☐ Atherosclerotic cardiovascular disease (ASCVD) i.e. heart attacks/strokes

3. Medication is being prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipidologist: ☐ Yes ☐ No
   
   **Action required:** If not in a specialty clinic or written by a specialist, information on annual consult with an appropriate specialist is required:

   - Name of specialist: __________________________ Contact date: _________________

4. Member has (low-density lipoproteins) LDL-cholesterol level equal to or greater than 70mg/dl:
   - ☐ Yes ☐ No

   **Please provide baseline LDL:** __________________________ Date: __________________________

   **Note:** If LDL levels can not be determined due to high triglycerides, direct LDL-C testing is required.

5. Member has trialed at least two high-intensity statins at maximum tolerated doses for at least 12 weeks:

   - First statin used/dose: __________________________ Statin dates: __________________________
     
     Reason for discontinuation: __________________________

   - Second statin used/dose: __________________________ Statin dates: __________________________
     
     Reason for discontinuation: __________________________

6. Member will continue receiving a maximally tolerated high-intensity statin: ☐ Yes ☐ No

   **Drug name:** __________________________

   **If no, please indicate the reason:** __________________________

7. Member has trialed ezetimibe for at least 12 weeks: ☐ Yes ☐ No
Dates of use: ____________________ Reason for discontinuation: ____________________

8. Member will not take Leqvio® in combination with Juxtapid®, Repatha® or Praluent®: □ Yes  □ No

LIMITATIONS:

Maximum dose allowed: 284mcg at initial fill and at 3 months, then 284mcg every 6 months after

Initial authorization will be granted for 9 months.

☐ CONTINUATION OF THERAPY

1. Member has been adherent to Leqvio®: □ Yes  □ No
2. Member has been adherent to statin at maximally tolerated dose: □ Yes  □ No
3. Member has demonstrated positive clinical improvement (i.e., reduction in LDL-C): □ Yes  □ No

Action required: Please attach lab work.

4. Annual specialist consult attached if prescriber is not a specialist: □ Yes  □ No  □ N/A – prescriber is a specialist.

LIMITATIONS:

Maximum dose allowed: 284mcg every 6 months

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.