# Leqvio® (inclisiran)
## (Subcutaneous)

Document Number: IC-0652

**Last Review Date: 08/04/2026**
**Date of Origin: 02/01/2022**
**Dates Reviewed: 02/2022, 07/2022, 04/2023, 08/2023, 04/2024, 08/2025, 03/2026, 08/2026**

## I. Length of Authorization

- Initial: Prior authorization validity will be provided initially for 6 months (180 days).
- Renewal: Prior authorization validity may be renewed every 12 months (365 days) thereafter.

## II. Dosing Limits

**Max Units (per dose and over time) [HCPCS Unit]:**

- 284 billable units (284 mg) at months 0, 3 and then every 6 months

## III. Initial Approval Criteria [1]

Prior authorization validity is provided in the following conditions:

- Patient must have a contraindication, intolerance, or failure to **Repatha® AND Praluent®** prior to consideration of Leqvio®; **AND**
- Baseline low-density lipoprotein cholesterol (LDL-C) labs have been obtained prior to initiating treatment (required for renewal); **AND**

**Universal Criteria [1]**

- Member is not on concomitant treatment with another PCSK9-inhibitor; **AND**
- Must be prescribed by, or in consultation with, a specialist in cardiology, lipidology, or endocrinology; **AND**
- Therapy will be used in conjunction with diet and exercise; **AND**

**Hypercholesterolemia † [1,13,16,17,27,28]**

- Member is at least 18 years of age; **AND**
- Member has prior treatment history with the highest available age-appropriate dose or maximally-tolerated dose* of high intensity statin therapy (i.e., atorvastatin 40 mg or 80 mg daily OR rosuvastatin 20 mg or 40 mg daily), unless contraindicated; **AND**
- Member has failed to reach a target LDL-C despite physician attestation that the member is adherent to maximally-tolerated doses* of statins prior to the lipid panel demonstrating suboptimal reduction; **AND**
    - Member has clinical atherosclerotic cardiovascular disease (ASCVD) (i.e., acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other

arterial revascularization, stroke, transient ischemic attack, or peripheral arterial disease presumed to be of atherosclerotic origin, including aortic aneurysm); **OR**

- Member does NOT have clinical ASCVD; **AND**
  - Member has treated LDL-C ≥ 100 mg/dL; **OR**
  - Member has treated LDL-C ≥ 70 mg/dL with subclinical atherosclerosis or additional ASCVD risk factors

**Heterozygous Familial Hypercholesterolemia (HeFH) †** [1,13,16,20,21,23,27,28]

- Member is at least 12 years of age; **AND**
- Member has prior treatment history with the highest available age-appropriate dose or maximally-tolerated dose* of high intensity statin therapy (i.e., atorvastatin 40 mg or 80 mg daily OR rosuvastatin 20 mg or 40 mg daily), unless contraindicated; **AND**
- Member has failed to reach a target LDL-C despite physician attestation that the member is adherent to maximally-tolerated doses* of statins prior to the lipid panel demonstrating suboptimal reduction; **AND**
- Member diagnosis has been confirmed by ONE of the following:
  - Positive genetic testing to confirm mutation in the *LDLR*, *apoB*, or *PCSK9* gene(s)
  - History of LDL-C greater than 190 mg/dL
  - Member has clinical manifestations of HeFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea)
  - Probable or definite diagnosis of HeFH according to Simon Broome diagnostic criteria**§**
  - Probable or definite diagnosis of HeFH according to the Dutch Lipid Clinic diagnostic criteria**¥**

**Homozygous Familial Hypercholesterolemia (HoFH) † Φ** [1,13,24-28]

- Member is 12 to 17 years of age; **AND**
- Member diagnosis has been confirmed by ONE of the following:
  - Confirmed DNA test for functional mutation(s) in low-density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality [i.e. *LDLR*, *LDLRAP1, ARH, PCSK9*, or *apoB* gene(s)]; **OR**
  - Untreated LDL-C > 400 mg/dL or treated LDL-C ≥ 300 mg/dL; **AND**
    - Cutaneous or tendon xanthoma before 10 years of age; **OR**
    - Untreated LDL-C levels in both parents consistent with HeFH; **AND**
- Therapy will be used in conjunction with other LDL-lowering therapies (e.g., statins, ezetimibe, evinacumab, lomitapide, bempedoic acid, LDL apheresis, etc.); **AND**
- Member has tried and failed at least a 3-month trial of adherent therapy with the highest available (or maximally tolerated*) dose of atorvastatin OR rosuvastatin, with or without other lipid lowering therapy, unless contraindicated; **AND**

- Member has failed to reach a target LDL-C despite physician attestation that the member is adherent to maximally-tolerated doses* of statins prior to the lipid panel demonstrating suboptimal reduction

† FDA Approved Indication(s); ‡ Compendia Recommended Indication(s); Φ Orphan Drug

*If the member is not able to use a maximum dose of atorvastatin or rosuvastatin due to muscle symptoms, a causal relationship must be established between statin use and muscle symptoms.

- Member has evidence of pain, tenderness, stiffness, cramping, weakness, and/or fatigue and all of the following:
  - Muscle symptoms resolve after discontinuation of statin; **AND**
  - Muscle symptoms occurred when re-challenged at a lower dose of the same statin; **AND**
  - Muscle symptoms occurred after switching to an alternative statin; **AND**
  - Non-statin causes of muscle symptoms (e.g., hypothyroidism, reduced renal function, reduced hepatic function, rheumatologic disorders, such as polymyalgia rheumatica, steroid myopathy, vitamin D deficiency, or primary muscle disease) have been ruled-out; **OR**
- The member has been diagnosed with rhabdomyolysis associated with statin use; **AND**
  - The diagnosis should be supported by acute neuromuscular illness or dark urine AND an acute elevation in creatine kinase (usually > 5,000 IU/L or 5 times the upper limit of normal [ULN])

| § Simon Broome diagnostic criteria for HeFH [3,20,21] | |
|---|---|
| **Criteria** | **Description** |
| a | • Adults: Total cholesterol concentration above 7.5 mmol/liter (290 mg/dL) **OR** LDL-C concentration above 4.9 mmol/liter (189 mg/dL)<br>• Pediatrics: Total cholesterol level above 6.7 mmol/liter (260 mg/dL) **OR** LDL-C concentration above 4.0 mmol/liter (155 mg/dL) |
| b | Presence of tendinous xanthomata **OR** family history of tendinous xanthoma in a first- or second-degree relative |
| c | DNA-based evidence of mutation in the *LDLR*, *PCSK9*, or *APOB* gene |
| d | Family history of myocardial infarction before age 50 years in a second-degree relative or before age 60 years in a first-degree relative |
| e | Family history of raised total cholesterol concentration above 7.5 mmol/liter (290 mg/dL) in an adult first- or second-degree relative, or above 6.7 mmol/L (260 mg/dL) in a child, brother or sister aged younger than 16 years |
| ***NOTE:*** A "definite" FH diagnosis requires either criteria a and b, or criterion c. A "probable" FH diagnosis requires either criteria a and d, or criteria a and e. | |

| ¥ Dutch Lipid Clinic network diagnostic criteria for HeFH [3,20] | |
|---|---|
| **Criteria** | **Points** |
| Family history<br>– First-degree relative with known premature (men: <55 years; women: <60 years) coronary or vascular disease; **OR**<br>– First-degree relative with known LDL-C above the 95th percentile | 1 |
| **AND/OR**<br>– First-degree relative with tendinous xanthomata and/or arcus cornealis; **OR**<br>– Children < 18 years with LDL-C above the 95th percentile | 2 |

| | |
|---|---|
| Clinical history:<br>– Premature (men: <55 years; women: <60 years) coronary artery disease<br>**AND/OR**<br>– Premature (men: <55 years; women: <60 years) cerebral or peripheral vascular disease | 2<br><br>1 |
| Physical examination:<br>– Tendinous xanthomata<br>**OR**<br>– Arcus cornealis before age 45 years | 6<br><br>4 |
| LCL-C levels<br>– LDL-C ≥8.5 mmol/L (325 mg/dL)<br>– LDL-C 6.5 to 8.4 mmol/L (251-325 mg/dL)<br>– LCL-C 5 to 6.4 mmol/L (191-250 mg/dL)<br>– LCL-C 4 to 4.9 mmol/L (155-190 mg/dL) | 8<br>5<br>3<br>1 |
| DNA analysis:<br>– Functional mutation in the LDLR, apoB, or PCSK9 gene | 8 |
| ***NOTE:*** Choose only the highest score per point grouping. Diagnosis is based on the total number of points obtained:<br>• A "definite" FH diagnosis requires >8 points<br>• A "probable" FH diagnosis requires 6 to 8 points<br>• A "possible" FH diagnosis requires 3 to 5 points | |

## IV. Renewal Criteria [1,27]

Prior authorization validity may be renewed based upon the following criteria:

- Member continues to meet the universal and other indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in section III; **AND**
- Absence of unacceptable toxicity from therapy. Examples of unacceptable toxicity include: severe hypersensitivity reactions, etc.; **AND**
- Member has had a reduction in LDL-C when compared to the baseline labs (prior to initiating inclisiran)

## V. Dosage/Administration [1]

| Indication | Dose |
|---|---|
| All Indications | Administer 284 mg as a subcutaneous injection initially, again at 3 months, and then every 6 months. |
| – *Assess LDL-C when clinically indicated. The LDL-lowering effect of Leqvio may be measured as early as 30 days after initiation and anytime thereafter without regard to timing of the dose.*<br>– *Leqvio should be administered by a healthcare professional.*<br>– *Inject Leqvio subcutaneously into the abdomen, upper arm, or thigh. Do not inject in areas of active skin disease or injury, such as sunburns, skin rashes, inflammation, or skin infections.* | |

## VI. Billing Code/Availability Information

HCPCS Code:

- J1306 – Injection, inclisiran, 1 mg; 1 billable unit = 1 mg

NDC:

- Leqvio 284 mg/1.5 mL single-dose prefilled syringe: 00078-1000-xx

## VII. References


1. Leqvio [package insert]. East Hanover, NJ; Novartis Pharmaceuticals Corporation; February 2026. Accessed July 2026.
2. Mozaffarian D, et al. Heart disease and stroke statistics--2015 update: a report from the American Heart Association. Circulation. 2015 Jan 27;131(4):e29-322. doi: 10.1161/CIR.0000000000000152. Epub 2014 Dec 17.
3. Rosenson RS, Hegele RA, Endo C. (2026) Familial hypercholesterolemia in adults: Overview. In: Freeman MW, Botkin NF(Eds). *UpToDate.* Last updated: June 09, 2026. Accessed July 07, 2026. Available from: https://www.uptodate.com/contents/familial-hypercholesterolemia-in-adults-overview.
4. Ferranti et al. What is the prevalence of familial hypercholesterolemia in the US? AHA 2014; 130(A19656).
5. Stone NJ, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation, 2014; 129(25 Suppl 2): S1–45.
6. Jacobson et al. National Lipid Association recommendations for patient-centered management of dyslipidemia: Part 1 – executive summary. Journal of Clinical Lipidology. 2014. Available at: http://www.sciencedirect.com/science/article/pii/S1933287414002748. Accessed July 29, 2015.
7. Cannon CP. Ezetimibe Added to Statin Therapy after Acute Coronary Syndromes. N Engl J Med 2015; 372:2387–2397. doi: 10.1056/NEJMoa1410489.
8. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2017 Focused Update of the 2016 ACC Expert Consensus Decision Pathway on the Role of Non-Statin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Task Force on Expert Consensus Decision Pathways. J Am Coll Cardiol. 2017 Oct 3;70(14):1785-1822.
9. Grundy SM, Stone NJ, Bailey AL, et al. AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2018;000:e1–e120. DOI: 10.1161/CIR.0000000000000625.
10. Jacobson TA, Ito MK, Maki KC, et al. National Lipid Association recommendations for patient-centered management of dyslipidemia: Part 1 – executive summary. Journal of Clinical Lipidology. 2014:8(5):473–488. DOI: 10.1016/j.jacl.2014.07.007.

11. Jacobson TA, Maki KC, Orringer C, et al. National Lipid Association Recommendations for Patient-Centered Management of Dyslipidemia: Part 2. J Clin Lipidol. 2015 Nov-Dec;9(6 Suppl):S1-122.e1. doi: 10.1016/j.jacl.2015.09.002.
12. Robinson JG, Jayanna MB, Brown AS, et al. Enhancing the Value of PCSK9 Monoclonal Antibodies by Identifying Patients Most Likely to Benefit, Journal of Clinical Lipidology (2019), doi: https://doi.org/10.1016/j.jacl.2019.05.005
13. Rosenson RS, Baker SK, Jacobson TA, et al, The National Lipid Association's Muscle Safety Expert Panel. An assessment by the Statin Muscle Safety Task Force: 2014 update. J Clin Lipidol. 2014 May-Jun;8(3 Suppl):S58-71. doi: 10.1016/j.jacl.2014.03.004.
14. Orringer, CE, Jacobson TA, Saseen JJ, et al. Update on the use of PCSK9 inhibitors in adults: Recommendations from an Expert Panel of the National Lipid Association. Journal of Clinical Lipidology. 2017, Vol: 11, Issue: 4, Page: 880-890.
15. Al-Rasadi K, Al-Waili K, Al-Sabti HA, et al. Criteria for Diagnosis of Familial Hypercholesterolemia: A Comprehensive Analysis of the Different Guidelines, Appraising their Suitability in the Omani Arab Population. Oman Med J. 2014;29(2):85-91. doi:10.5001/omj.2014.22.
16. Raal FJ, Kallend D, Ray KK, et al; ORION-9 Investigators. Inclisiran for the Treatment of Heterozygous Familial Hypercholesterolemia. N Engl J Med. 2020 Apr 16;382(16):1520-1530. doi: 10.1056/NEJMoa1913805. Epub 2020 Mar 18.
17. Ray KK, Wright RS, Kallend D, et al; ORION-10 and ORION-11 Investigators. Two Phase 3 Trials of Inclisiran in Patients with Elevated LDL Cholesterol. N Engl J Med. 2020 Apr 16;382(16):1507-1519. doi: 10.1056/NEJMoa1912387. Epub 2020 Mar 18.
18. Lloyd-Jones DM, Morris PB, Ballantyne CM, et al. 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies for LDL-Cholesterol Lowering in the Management of Atherosclerotic Cardiovascular Disease Risk: A Report of the American College of Cardiology Solution Set Oversight Committee. J Am Coll Cardiol. 2022 Oct 4;80(14):1366-1418. doi: 10.1016/j.jacc.2022.07.006.
19. Mach, F, Baigent C, Catapano A et al. 2019 ESC/EAS Guidelines for the management of dyslipidaemias: *lipid modification to reduce cardiovascular risk*: The Task Force for the management of dyslipidaemias of the European Society of Cardiology (ESC) and European Atherosclerosis Society (EAS), *European Heart Journal*, Volume 41, Issue 1, 1 January 2020, Pages 111–188, https://doi.org/10.1093/eurheartj/ehz455
20. Orringer CE, Jacobson TA, Saseen JJ, et al. Update on the use of PCSK9 inhibitors in adults: Recommendations from an Expert Panel of the National Lipid Association. J Clin Lipidol. 2017 Jul-Aug;11(4):880-890. doi: 10.1016/j.jacl.2017.05.001. Epub 2017 May 19. PMID: 28532784.
21. National Collaborating Centre for Primary Care (UK). Identification and Management of Familial Hypercholesterolaemia (FH) [Internet]. London: Royal College of General Practitioners (UK); 2008 Aug. (NICE Clinical Guidelines, No. 71.) Appendix F, Simon Broome Diagnostic criteria for index individuals and relatives. Available from: https://www.ncbi.nlm.nih.gov/books/NBK53810/
22. WHO Human Genetics Programme. (1999). Familial hypercholesterolaemia (FH) : report of a second WHO consultation, Geneva, 4 September 1998. World Health Organization.

23. Wiegman A, Peterson AL, Bruckert E, et al. Efficacy and safety of inclisiran in adolescents with heterozygous familial hypercholesterolaemia (ORION-16): a two-part, randomised, multicentre clinical trial. *Lancet Diabetes Endocrinol*. Published online January 27, 2026. doi:10.1016/S2213-8587(25)00351-1
24. Wiegman A, Peterson AL, Hegele RA, et al. Efficacy and Safety of Inclisiran in Adolescents With Genetically Confirmed Homozygous Familial Hypercholesterolemia: Results From the Double-Blind, Placebo-Controlled Part of the ORION-13 Randomized Trial. *Circulation*. 2025;151(25):1758-1766. doi:10.1161/CIRCULATIONAHA.124.073233
25. Cuchel M, Raal FJ, Hegele RA, et al. 2023 Update on European Atherosclerosis Society Consensus Statement on Homozygous Familial Hypercholesterolaemia: new treatments and clinical guidance. European Heart Journal. 2023;44(25):2277-2291. doi:10.1093/eurheartj/ehad197
26. Cegla J, Walji S, Barton L, et al. Treatment of Homozygous Familial Hypercholesterolemia. JACC Adv. 2025 May;4(5):101708. doi: 10.1016/j.jacadv.2025.101708. Epub 2025 Apr 26. PMID: 40288084; PMCID: PMC12059681.
27. Blumenthal, R, Morris, P, Gaudino, M. et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. JACC. 2026 May, 87 (19) 2624–2757. https://doi.org/10.1016/j.jacc.2025.11.016
28. Warden B, Guyton J, Kovacs A, et.al. Assessment and management of statin-associated muscle symptoms (SAMS): A clinical perspective from the National Lipid Association. Journal of Clinical Lipidology, 2022; 17, 19-39. doi: 10.1016/j.jacl.2022.09.001

## Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist

Non-quantitative treatment limitations (NQTLs) refer to the methods, guidelines, standards of evidence, or other conditions that can restrict how long or to what extent benefits are provided under a health plan. These may include things like utilization review or prior authorization. The utilization management NQTL applies comparably, and not more stringently, to mental health/substance use disorder (MH/SUD) Medical Benefit Prescription Drugs and medical/surgical (M/S) Medical Benefit Prescription Drugs. The table below lists the factors that were considered in designing and applying prior authorization to this drug/drug group, and a summary of the conclusions that Prime's assessment led to for each.

| Factor | Conclusion |
|---|---|
| Indication | Yes: Consider for PA |
| Safety and efficacy | No: PA not a priority |
| Potential for misuse/abuse | No: PA not a priority |
| Cost of drug | Yes: Consider for PA |

## Appendix 1 – Covered Diagnosis Codes

| ICD-10 | ICD-10 Description |
|---|---|
| E75.5 | Other lipid storage disorders |
| E78.00 | Pure Hypercholesterolemia, unspecified |
| E78.010 | Homozygous familial hypercholesterolemia [HoFH] |
| E78.011 | Heterozygous familial hypercholesterolemia [HeFH] |
| E78.019 | Familial hypercholesterolemia, unspecified |
| E78.2 | Mixed hyperlipidemia |
| E78.49 | Other hyperlipidemia, familial combined hyperlipidemia |
| E78.5 | Hyperlipidemia, unspecified |

## Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

The preceding information is intended for non-Medicare coverage determinations. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered. The following link may be used to search for NCD, LCD, or LCA documents: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications, including any preceding information, may be applied at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD/LCA): N/A

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| **Jurisdiction** | **Applicable State/US Territory** | **Contractor** |
| E (1) | CA, HI, NV, AS, GU, CNMI | Noridian Healthcare Solutions, LLC |
| F (2 & 3) | AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ | Noridian Healthcare Solutions, LLC |
| 5 | KS, NE, IA, MO | Wisconsin Physicians Service Insurance Corp (WPS) |
| 6 | MN, WI, IL | National Government Services, Inc. (NGS) |
| H (4 & 7) | LA, AR, MS, TX, OK, CO, NM | Novitas Solutions, Inc. |
| 8 | MI, IN | Wisconsin Physicians Service Insurance Corp (WPS) |
| N (9) | FL, PR, VI | First Coast Service Options, Inc. |
| J (10) | TN, GA, AL | Palmetto GBA |
| M (11) | NC, SC, WV, VA (excluding below) | Palmetto GBA |
| L (12) | DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA) | Novitas Solutions, Inc. |

| Medicare Part B Administrative Contractor (MAC) Jurisdictions | | |
|---|---|---|
| **Jurisdiction** | **Applicable State/US Territory** | **Contractor** |
| K (13 & 14) | NY, CT, MA, RI, VT, ME, NH | National Government Services, Inc. (NGS) |
| 15 | KY, OH | CGS Administrators, LLC |