

# PHARMACY POLICY STATEMENT

## Ohio Medicaid

<b>DRUG NAME</b>	<b>Leqvio (inclisiran)</b>
<b>BENEFIT TYPE</b>	Medical
<b>STATUS</b>	Prior Authorization Required

Leqvio, approved by the FDA in 2021, is a small interfering RNA (siRNA) directed to proprotein convertase subtilisin kexin type 9 (PCSK9) messenger RNA (mRNA) indicated as an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH).

Leqvio is a first-in-class siRNA that targets PCSK9 to inhibit its production in the liver, prolonging LDL receptor activity. Following induction, it is administered every 6 months by a healthcare professional, which may be beneficial for adherence in comparison to the PCSK9 monoclonal antibody (mAb) drugs.

Leqvio (inclisiran) will be considered for coverage when the following criteria are met:

### Heterozygous Familial Hypercholesterolemia (HeFH)

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Medication must be prescribed by or in consultation with cardiologist, endocrinologist, or lipid specialist; AND
3. Member has a diagnosis of HeFH as documented by one of the following:
  - a) Genetic testing (presence of LDL-R, ApoB, or PCSK9 mutation)
  - b) Dutch Lipid Network score greater than 8 points
  - c) “Definite” per Simon Broome criteria (i.e., LDL > 190 at baseline AND tendon xanthoma OR LDL-R, ApoB, or PCSK9 mutation); AND
4. Member has a lipid panel within the past 90 days showing LDL of 100 or greater; AND
5. Member’s LDL is elevated despite at least a 3-month adherent trial of high intensity or max tolerated statin therapy in combination with ezetimibe (unless there is documentation of clearly established statin intolerance or statin contraindication—see note\*); AND
6. Leqvio will be taken as an adjunct to diet and maximum tolerated statin therapy; AND
7. Member will NOT be concomitantly taking a PCSK9 mAb (e.g., Repatha, Praluent).
8. **Dosage allowed/Quantity limit:** 284 mg as a single subQ injection initially, again at 3 months, and every 6 months thereafter.  
(QL: 2 syringes per 84 days for the first fill, then 1 syringe per 180 days thereafter; 1 syringe = 1.5 mL)

*\*Note: If not on statin therapy, member must have documented contraindication to all statin drugs or documentation of intolerance to at least 2 different statins, including low/moderate intensity or alternate dosing such as every other day.*

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Documentation in chart notes must demonstrate clinically meaningful LDL reduction compared to pre-treatment baseline.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

## Hypercholesterolemia

For **initial** authorization:

1. Member is at least 18 years of age; AND
2. Member has one of the following:
  - a) Diagnosis of ASCVD (e.g., coronary heart disease [CHD], cardiovascular disease [CVD], or peripheral arterial disease [PAD])
  - b) ASCVD risk factor such as metabolic syndrome, chronic kidney disease, diabetes, or coronary artery calcium (CAC) score >300; AND
3. Member has a lipid panel within the past 90 days showing an LDL of 70 mg/dL or greater despite at least a 3-month adherent trial of high intensity or max tolerated statin therapy in combination with ezetimibe (unless there is documentation of clearly established statin intolerance or statin contraindication—see note\*); AND
4. Leqvio will be taken as an adjunct to diet, exercise, and maximum tolerated statin therapy; AND
5. Member will NOT be concomitantly taking a PCSK9 mAb (e.g., Repatha, Praluent).
6. **Dosage allowed/Quantity limit:** 284 mg as a single subQ injection initially, again at 3 months, and every 6 months thereafter.  
(QL: 2 syringes per 84 days for the first fill, then 1 syringe per 180 days thereafter; 1 syringe = 1.5 mL)

*\*Note: If not on statin therapy, member must have documented contraindication to all statin drugs or documentation of intolerance to at least 2 different statins, including low/moderate intensity or alternate dosing such as every other day.*

***If all the above requirements are met, the medication will be approved for 6 months.***

For **reauthorization**:

1. Documentation in chart notes must demonstrate clinically meaningful LDL reduction compared to pre-treatment baseline.

***If all the above requirements are met, the medication will be approved for an additional 12 months.***

**CareSource considers Leqvio (inclisiran) not medically necessary for the treatment of conditions that are not listed in this document. For any other indication, please refer to the Off-Label policy.**

DATE	ACTION/DESCRIPTION
01/24/2022	New policy created for Leqvio.
07/28/2023	Updated policy for label expansion to include primary hyperlipidemia/primary prevention (increased risk for ASCVD) rather than just the original ASCVD/secondary prevention population. Updated concomitant exclusion terminology to say PCSK9 mAB instead of PCSK9 inhibitor. Added detail to statin intolerance note regarding low/moderate intensity and alternate dosing. Changed LDL cutoff to 90 days instead of

	30. Differentiated LDL cutoff of 55 for “very high risk” population. Added references. Added Simon Broome as option to meet diagnosis for HeFH.
<b>05/03/2024</b>	Added QL.
<b>10/14/2025</b>	Updated references. Changed “Primary Hyperlipidemia” header to “Hypercholesterolemia.” Removed criteria option for LDL of 55 cut-off (AACE 2025); updated examples of ASCVD risk factors. Combined criteria for LDL goal and statin/ezetimibe trials. Added “exercise” to match label indication wording. ODM approved on 01/28/26.

References:

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4. McGowan MP, Hosseini Dehkordi SH, Moriarty PM, Duell PB. Diagnosis and Treatment of Heterozygous Familial Hypercholesterolemia. *J Am Heart Assoc*. 2019;8(24):e013225. doi:10.1161/JAHA.119.013225
5. Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC Guideline on the Management of Blood Cholesterol. *JACC*. 2018;73(24):doi:10.1016/j.jacc.2018.11.002.
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10. Ohio Administrative Code. (2022, February 23). 5160-1-01 (C) Medicaid medical necessity: definitions and principles. Retrieved February 22 2023 from codes.ohio.gov.
11. Ohio Administrative Code. (2022, July 18). 5160-26-03 Managed care: covered services. Retrieved February 22, 2023 from codes.ohio.gov.
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