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

Libtayo
(cemiplimab-rwlc)

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:
☐ Libtayo ☐ other (please specify): ICD10:

Directions for use: Dose: Quantity: Duration of therapy:

Where will this medication be obtained?
☐ Prescriber's office stock (billing on a medical claim form) ☐ Home Health / Home Infusion vendor
☐ 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

Diagnosis related to use:
☐ Basal cell carcinoma (BCC)
☐ Cutaneous squamous cell carcinoma (CSCC)
☐ Non-small cell lung cancer (NSCLC)
☐ other *(please specify):*

Clinical Information
(if CSCC) Does your patient have metastatic or locally advanced disease? Yes ☐ No ☐
(if CSCC) Is your patient a candidate for curative surgery or radiation? Yes ☐ No ☐
(if BCC) Does your patient have locally advanced disease (also known as laBCC)? Yes ☐ No ☐
(if no) Does your patient have metastatic disease (also known as mBCC)? Yes ☐ No ☐
(if BCC) Has your patient previously been treated with a hedgehog pathway inhibitor (HHI), such as Daurismo, Erivedge, or Odomzo? Yes ☐ No ☐
(if no) Is treatment with a hedgehog pathway inhibitor (HHI) (such as Daurismo, Erivedge, or Odomzo) not considered appropriate for this patient? Yes ☐ No ☐
(if NSCLC) Is this medication the only one your patient will be using at this time for this diagnosis? Yes ☐ No ☐
(if NSCLC) Does your patient have advanced disease? Yes ☐ No ☐
(if NSCLC) Is this medication part of the first therapy given for this diagnosis? Yes ☐ No ☐
(if NSCLC) Does your patient's tumor have PD-L1 expression of 50% or more? Yes ☐ No ☐
(if NSCLC) Is your patient a candidate for surgical resection or definitive chemoradiation? Yes ☐ No ☐
(if NSCLC) Does your patient's tumor have any EGFR, ALK, or ROS1 abberrations? Yes ☐ No ☐

Additional pertinent information *(please include disease stage, prior therapy, performance status, and names/doses/admin schedule of any agents to be used concurrently)*:

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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