



Libtayo

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider

Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Libtayo SGM – 04/2022.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Criteria Questions:

1. What is the diagnosis?
 Cutaneous squamous cell carcinoma
 Basal cell carcinoma
 Non-small cell lung cancer
 Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy? Yes No
4. Is the patient currently receiving the requested medication? Yes No *If No, skip to diagnosis section*
5. Has the patient experienced disease progression or an unacceptable toxicity while on the current? Yes No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cutaneous Squamous Cell Carcinoma

6. How is the patient's disease classified?
 Metastatic disease, *skip to #8*
 Locally advanced disease, *skip to #8*
 Regional disease
 Other _____
7. Is the disease inoperable or incompletely resected? Yes No
8. Is the patient a candidate for curative surgery or curative radiation? Yes No *No further questions*

Section B: Basal Cell Carcinoma

9. How is the patient's disease classified?
 Metastatic disease
 Advanced disease
 Diffuse disease (e.g., Gorlin syndrome)
 Recurrent disease
 Other _____
10. Has the patient received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo])? Yes *If Yes, no further questions* No
11. Is a hedgehog pathway inhibitor appropriate for the patient? Yes No *No further questions*

Section C: Non-Small Cell Lung Cancer

12. What is the clinical setting in which the requested drug will be used?
 First-line treatment, *skip to #14*
 Continued maintenance therapy
 Other
13. Is there tumor response or stable disease following first-line cemiplimab-rwlc therapy? Yes No
14. Does the tumor have high PD-L1 expression [Tumor Proportion Score (TPS) \geq 50%]? ***ACTION REQUIRED: Please attach documentation of programmed death ligand 1 (PD-L1) tumor expression.***
 Yes No Unknown
15. Does the tumor have EGFR, ALK, ROS1 and RET aberrations? ***ACTION REQUIRED: Please attach documentation of EGFR, ALK, ROS1, and RET status.***
 Yes No *If No, skip to #17* Unknown
16. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue? Yes No

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17. How is the patient's disease classified?

- Metastatic disease
- Advanced disease
- Recurrent disease
- Other _____

18. Will the requested drug be used as a single agent? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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