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?
☐ Onco360
☐ 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)
☐ Cervical cancer
☐ Cutaneous squamous cell carcinoma (CSCC)
☐ Non-small cell lung cancer (NSCLC)
☐ Vulvar cancer
☐ other *(please specify):*

Clinical Information
Is this a new start or continuation of therapy? If your patient has already begun treatment with samples, please choose "new start of therapy".
☐ New start of therapy
☐ Continuation of therapy

(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 Cervical, NSCLC, or Vulvar) Is this medication the only one your patient will be using at this time for this diagnosis? Yes ☐ No ☐

(if NSCLC and single-agent) Is this medication the first therapy given for this diagnosis? Yes ☐ No ☐

(if NSCLC and single-agent) Does the patient have advanced disease? Yes ☐ No ☐

(if NSCLC and single-agent) Does your patient's tumor have PD-L1 expression of 50% or more?	Yes ☐	No ☐
(if NSCLC and single-agent) Is your patient a candidate for surgical resection or definitive chemoradiation?	Yes ☐	No ☐
(if NSCLC and single-agent) Does your patient's tumor have any EGFR, ALK, or ROS1 aberrations?	Yes ☐	No ☐
(if NSCLC and not single-agent) Will this medication be used in combination with platinum-based chemotherapy?	Yes ☐	No ☐
(if NSCLC and not single-agent) Is this medication the first therapy given for this diagnosis?	Yes ☐	No ☐
(if NSCLC and not single-agent) Does your patient's tumor have any EGFR, ALK, or ROS1 aberrations?	Yes ☐	No ☐
(if NSCLC and not single-agent) Does your patient have metastatic disease?	Yes ☐	No ☐
(if not metastatic) Does the patient have locally advanced disease?	Yes ☐	No ☐
if not metastatic) Is the patient a candidate for surgical resection or definitive chemoradiation?	Yes ☐	No ☐
(if cervical or vulvar) Will this medication be used as second line or subsequent therapy?	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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