



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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Libtayo <input type="checkbox"/> other (please specify): _____ ICD10: _____ Directions for use: _____ Dose: _____ Quantity: _____ Duration of therapy: _____					
Where will this medication be obtained? <input type="checkbox"/> Onco360 <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use: <input type="checkbox"/> Anal carcinoma <input type="checkbox"/> Appendiceal adenocarcinoma <input type="checkbox"/> Basal cell carcinoma (BCC) <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Colorectal cancer <input type="checkbox"/> Cutaneous squamous cell carcinoma (CSCC) <input type="checkbox"/> Non-small cell lung cancer (NSCLC) <input type="checkbox"/> Small bowel adenocarcinoma <input type="checkbox"/> Vaginal cancer <input type="checkbox"/> Vulvar cancer <input type="checkbox"/> other					
Clinical Information (if CSCC) Does the patient have metastatic or locally advanced disease? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes) Is the patient a candidate for curative surgery or radiation? Yes <input type="checkbox"/> No <input type="checkbox"/> (if not metastatic or locally advanced OR is a candidate for surgery or radiation) Will the requested medication be used as adjuvant treatment for a patient at high risk of recurrence after surgery and radiation? Yes <input type="checkbox"/> No <input type="checkbox"/> (if BCC) Does the patient have locally advanced disease (also known as laBCC)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Does the patient have metastatic disease (also known as mBCC)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if BCC) Has the patient previously been treated with a hedgehog pathway inhibitor (HHI)? Yes <input type="checkbox"/> No <input type="checkbox"/>					

- (if no) Is treatment with a hedgehog pathway inhibitor (HHI) not considered appropriate for this patient? Yes No
- (if NSCLC) Will the requested medication be used as single agent therapy? Yes No
- (if NSCLC and single-agent) Is the requested 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 the patient's tumor have PD-L1 expression of 50% or more? Yes No
- (if NSCLC and single-agent) Is the patient a candidate for surgical resection or definitive chemoradiation? Yes No
- (if NSCLC and single-agent) Do the patient's tumors have any EGFR, ALK, or ROS1 aberrations? Yes No
- (if NSCLC and not single-agent) Will the requested medication be used in combination with platinum-based chemotherapy? Yes No
- (if NSCLC and not single-agent) Is the requested medication the first therapy given for this diagnosis? Yes No
- (if NSCLC and not single-agent) Do the patient's tumors have any EGFR, ALK, or ROS1 aberrations? Yes No
- (if NSCLC and not single-agent) Does the 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, vaginal, or vulvar cancer) Will the requested medication be used as single agent therapy? Yes No
- (if cervical, vaginal, or vulvar) Will the requested medication be used as second line or subsequent therapy? Yes No
- (if anal carcinoma) Will the requested medication be used as single agent therapy? Yes No
- (if anal carcinoma) Is the requested medication being requested for treatment before proceeding to abdominoperineal resection? Yes No
- (if anal carcinoma) Does the patient have locally recurrent, progressive disease? Yes No
- (if appendiceal adenocarcinoma) Is the requested medication to be used as systemic therapy for advanced or metastatic disease? Yes No
- (if appendiceal adenocarcinoma) Is the patient's disease considered to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) OR does the patient have a polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (for example, TMB greater than 50 mut/Mb)? Yes No
- (if appendiceal adenocarcinoma) Is the patient a candidate for immunotherapy? Yes No
- (if yes) Has the patient previously received any immunotherapy? Yes No
- (if colorectal cancer) Is the patient's disease considered to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) OR does the patient have a polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (for example, TMB greater than 50 mut/Mb)? Yes No
- (if colorectal cancer) Is the requested medication being used as neoadjuvant therapy for clinical T4b or bulky nodal disease? Yes No
- (if no) Is the requested medication being used as neoadjuvant therapy for resectable synchronous liver and/or lung metastases? Yes No
- (if yes) Has the patient previously received treatment with a checkpoint inhibitor? Yes No
- (if not neoadjuvant OR has previously received checkpoint inhibitor) Is the requested medication being used as initial treatment for resectable metachronous metastases? Yes No
- (if yes) Has the patient previously received any immunotherapy? Yes No
- (if small bowel adenocarcinoma) Is the patient's disease considered to be deficient mismatch repair/microsatellite instability-high (dMMR/MSI-H) OR does the patient have a polymerase epsilon/delta (POLE/POLD1) mutation with ultra-hypermutated phenotype (for example, TMB greater than 50 mut/Mb)? Yes No
- (if small bowel adenocarcinoma) Does the patient have locally unresectable or medically inoperable disease? Yes No
- (if yes) Is the requested medication being used for primary treatment of this disease? Yes No
- (if not locally unresectable or medically inoperable OR not for primary treatment) Does the patient have advanced or metastatic disease? Yes No

(if yes) Has the patient previously received treatment with a checkpoint inhibitor?

Yes No

(if appendiceal or small bowel adenocarcinoma, colorectal cancer) Will the requested medication be used as single agent therapy?

Yes No

Additional pertinent information:

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:** _____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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.

v020126

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005