OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Libtayo® (Cemiplimab-rwlc) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐***Physician billing (HCPCS code:_____)*** ☐***Pharmacy billing (NDC:_____)***

Dose:_____ Regimen:_____ Start Date (or date of next dose):_____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:

☐ **Basal Cell Carcinoma (BCC)**

A. Is disease locally advanced or metastatic? Yes☐ No☐

B. Has member previously been treated with a hedgehog pathway inhibitor (HHI)? Yes☐ No☐

i. If no, is an HHI appropriate for the member? Yes☐ No☐

☐ **Cutaneous Squamous Cell Carcinoma (CSCC)**

A. Is disease metastatic or locally advanced? Yes☐ No☐

B. Is member eligible for curative surgery or radiation? Yes☐ No☐

C. Has member received prior immunotherapy agent(s) [e.g., Keytruda® (pembrolizumab), Opdivo® (nivolumab), Yervoy® (ipilimumab)]? Yes☐ No☐

☐ **Non-Small Cell Lung Cancer (NSCLC)**

A. Is disease advanced, unresectable, or metastatic? Yes☐ No☐

B. Will cemiplimab be used in the first-line setting? Yes☐ No☐

C. How will cemiplimab be used?

☐ Single agent

i. Does tumor express programmed death ligand 1 (PD-L1) [tumor proportion score (TPS) ≥50%]? Yes☐ No☐

☐ In conjunction with platinum-based chemotherapy

D. Is disease positive for epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or *ROS1* mutations? Yes☐ No☐

☐ **Other, please provide diagnosis:**_____

Additional Information: _____

_____

_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114

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Criteria

For Continued Authorization:

1. Date of last dose:_____
2. Does member have any evidence of progressive disease while on cemiplimab-rwlc therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to cemiplimab-rwlc therapy? Yes☐ No☐

*If yes, please specify adverse reactions:*_____

Additional Information: _____
_____
_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*