Libtayo® (cemiplimab-rwlc) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Libtayo (cemiplimab-rwlc): Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required for all requests):

☐ Yes ☐ No Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy before? (e.g., Bavencio (avelumab), Imfinzi (durvalumab), Keytruda (pembrolizumab), Opdivo (nivolumab), and Tecentriq (atezolizumab))?

For Initiation Requests (clinical documentation required for all requests):

Basal Cell Carcinoma
Please indicate how the patient's disease is classified:
☐ Metastatic disease ☐ Advanced disease ☐ Diffuse disease (e.g., Gorlin syndrome) ☐ Recurrent disease ☐ Other
☐ Yes ☐ No Has the patient received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo])?
→ ☐ Yes ☐ No Is a hedgehog pathway inhibitor appropriate for the patient?

Cutaneous Squamous Cell Carcinoma
☐ Yes ☐ No Is the patient a candidate for curative surgery or curative radiation?
Please indicate how the patient's disease is classified:
☐ Metastatic disease
☐ Locally advanced disease
☐ Regional disease
→ ☐ Yes ☐ No Is the disease inoperable or incompletely resected?
☐ Other

Continued on next page

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

Non-Small Cell Lung Cancer

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

Please indicate how the patient's disease classified: ☐ Metastatic disease ☐ Advanced disease ☐ Recurrent disease ☐ Other

☐ Yes ☐ No ☐ Unknown Does the tumor have high PD-L1 expression [Tumor Proportion Score (TPS) ≥ 50%]?

☐ Yes ☐ No ☐ Unknown Does the tumor have EGFR, ALK, ROS1 and RET aberrations?

→ ☐ Yes ☐ No Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?

Please indicate the clinical setting in which the requested drug will be used:

☐ First-line treatment

☐ Continued maintenance therapy

→ ☐ Yes ☐ No Is there tumor response or stable disease following first-line cemiplimab-rwlc therapy?

☐ Other

For Continuation Requests (clinical documentation required for all requests):

Please provide the start date of the requested medication: ____/____/____

☐ Yes ☐ No Has the patient experienced disease progression or unacceptable toxicity while on the current regimen?

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Is the patient continuing on a maintenance regimen that includes provider administered combination chemotherapy?

→ Please provide the regimen: _____

☐ Yes ☐ No Is the patient experiencing severe toxicity requiring continuous monitoring (e.g., Grade 2-4 bullous dermatitis, transaminitis, pneumonitis, Stevens-Johnson syndrome, acute pancreatitis, primary adrenal insufficiency aseptic meningitis, encephalitis, transverse myelitis, myocarditis, pericarditis, arrhythmias, impaired ventricular function, conduction abnormalities)?

→ Please explain: _____

☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

→ Please explain: _____

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

→ Please explain: _____

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please explain: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition:

☐ Cardiopulmonary: _____

☐ Respiratory: _____

☐ Renal: _____

☐ Other: _____

☐ Yes ☐ No Is the patient within the initial 6 months of starting therapy?

→ Please indicate how many continuous months of treatment the patient has received with the requested drug: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required)*: _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.