

Unloxcyt™ (cosibelimab-ipdl) Prior Authorization Form

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

Drug Information

Physician billing (HCPCS code: _____) Start Date (or date of next dose): _____

Dose: _____ Regimen: _____

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

- Is diagnosis metastatic or locally advanced CSCC? Yes ___ No ___
- Is member a candidate for curative surgery or curative radiation? Yes ___ No ___
- Has member received prior treatment with immune checkpoint inhibitor therapy? Yes ___ No ___
- Will Unloxcyt™ be used as a single agent? Yes ___ No ___

 Other: _____**Additional Information:** _____

_____**For Continued Authorization:**

- Date of last dose: _____
- Does member have any evidence of progressive disease while on Unloxcyt™? Yes ___ No ___
- Has the member experienced adverse drug reactions related to Unloxcyt™ therapy? Yes ___ No ___

If yes, please specify adverse reactions: _____

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:**University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization UnitFax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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