



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 \_\_\_

Cervical, Vaginal, or Vulvar Cancer

- a. Is disease recurrent or metastatic? Yes \_\_\_ No \_\_\_
- b. Will cemiplimab be used as second-line or subsequent therapy? Yes \_\_\_ No \_\_\_
- c. Will cemiplimab be used as a single-agent? Yes \_\_\_ No \_\_\_
- d. Has member received prior immunotherapy agent(s) [e.g., Keytruda® (pembrolizumab), Opdivo® (nivolumab), Yervoy® (ipilimumab)]? Yes \_\_\_ No \_\_\_

Cutaneous Squamous Cell Carcinoma (CSCC)

- a. Is disease metastatic or locally advanced? Yes \_\_\_ No \_\_\_
  - For very-high risk disease:
    - i. Will Libtayo® be used as neoadjuvant treatment when surgery alone may be insufficient? Yes \_\_\_ No \_\_\_
    - ii. Will Libtayo® be used as adjuvant treatment following surgery or radiation and member is at high risk of recurrence? Yes \_\_\_ No \_\_\_
  - For primary or recurrent disease:
    - i. Will Libtayo® be used for systemic therapy alone when curative surgery and curative radiation are not feasible? Yes \_\_\_ No \_\_\_

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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  
Option 4

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Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Member ID#: \_\_\_\_\_

**Criteria**

**For Initial Authorization:**

**1. Please indicate the diagnosis and information: (continued)**

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

Used as continuation maintenance therapy following first-line therapy with cemiplimab

i. In combination with perimetrexed? Yes \_\_\_ No \_\_\_

ii. As a single agent? Yes \_\_\_ No \_\_\_

**Other, please provide diagnosis:** \_\_\_\_\_

**For Continued Authorization:**

- 1. Date of last dose: \_\_\_\_\_
- 2. Does member have any evidence of progressive disease while on Libtayo® therapy? Yes \_\_\_ No \_\_\_
- 3. Has the member experienced any adverse drug reactions related to Libtayo® therapy? Yes \_\_\_ No \_\_\_

If yes, please specify adverse reactions: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**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.

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