# Libtayo

## CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

**Referring Provider Info:** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

**Rendering Provider Info:** ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Required Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:* _____*cm*

What is the ICD-10 code? _____

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

 Libtayo SGM 2757-A SOC 5374-A – 08/2024.

**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**

**Site of Service Questions (SOS):**

A. Where will this drug be administered?
- ❑ On Campus Outpatient Hospital, *continue to B*
- ❑ Off Campus Outpatient Hospital, *continue to B*
- ❑ Home infusion, *skip to Criteria Questions*
- ❑ Physician office, *skip to Criteria Questions*
- ❑ Ambulatory surgical, *skip to Criteria Questions*
- ❑ Pharmacy, *skip to Criteria Questions.*

B. Is the patient less than 14 years of age?
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to C*

C. Is the patient receiving provider-administered combination oncology therapy or other provider-administered drug therapies at the same visit? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to D*

D. Is this request to continue previously established treatment with the requested regimen?
- ❑ No – This is a new therapy request (patient has not received 6 months or more of requested regimen). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of existing treatment (patient has received requested regimen for 6 months). ***ACTION REQUIRED: Please attach supporting clinical documentation.*** *Skip to Clinical Criteria Questions*
- ❑ Yes – This is a continuation of an existing treatment (patient has received requested regimen for 7 months or greater – initial 6 months plus 45 days grace period), *Continue to E*

E. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, or other pre- medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to F*

F. Has the patient experienced 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, or conduction abnormalities)? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to G*

G. 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?
***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to H*

H. Does the patient have severe venous access issues that require the use of a special intervention only available in the outpatient hospital setting? ***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to I*

I. 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?
***ACTION REQUIRED: If Yes, please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No, *Continue to J*

J. Are ***all*** alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) **greater than** 30 miles from the patient's home? ***ACTION REQUIRED: If Yes, please attach supporting documentation.***
❑ Yes, *Continue to Clinical Criteria Questions* ❑ No, *Continue to Clinical Criteria Questions*

**Clinical Criteria Questions:**

1. What is the diagnosis?

❒ Basal cell carcinoma (BCC), *Continue to 2*

❒ Cervical cancer, *Continue to 2*

❒ Cutaneous squamous cell carcinoma (CSCC), *Continue to 2*

❒ Non-small cell lung cancer (NSCLC), *Continue to 2*

❒ Vulvar cancer, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy?
❒ Yes, *Continue to 3*
❒ No, *Continue to 3*

3. Is the patient currently receiving the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 7*

4. Is there evidence of disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is this request for continued treatment of basal cell carcinoma or cutaneous squamous cell carcinoma?
❒ Yes, *Continue to 6*
❒ No, *No Further Questions*

6. How many continuous months of treatment has the patient received with the requested medication?

_____months, *No further questions*

7. What is the diagnosis?

❒ Basal cell carcinoma (BCC), *Continue to 13*

❒ Cervical cancer, *Continue to 29*

❒ Cutaneous squamous cell carcinoma (CSCC), *Continue to 8*

❒ Non-small cell lung cancer (NSCLC), *Continue to 17*

❒ Vulvar cancer, *Continue to 26*

8. Will the requested medication be used as neoadjuvant treatment?
❒ Yes, *Continue to 9*
❒ No, *Continue to 10*

9. What is the clinical setting in which the requested medication will be used?

❒ Very high risk disease, *Continue to 12*

❒ Locally advanced disease, *Continue to 12*

❒ Unresectable disease, *Continue to 12*

❒ Regional disease, *Continue to 12*

❒ Other, please specify. _____, *Continue to 12*

10. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *Continue to 11*

❒ Locally advanced disease, *Continue to 11*

❒ Recurrent disease, *Continue to 11*

❒ Other, please specify. _____, *Continue to 11*

11. Is the patient a candidate for curative surgery or curative radiation?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

13. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *Continue to 15*

❒ Locally advanced disease, *Continue to 15*

❒ Nodal disease and surgery is not feasible, *Continue to 15*

❒ Other, please specify. _____, *Continue to 15*

15. Has the patient received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo])?
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

16. Is a hedgehog pathway inhibitor appropriate for the patient?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

17. What is the clinical setting in which the requested medication will be used?

❒ Metastatic disease, *Continue to 18*

❒ Advanced disease, *Continue to 18*

❒ Recurrent disease, *Continue to 18*

❒ Other, please specify. _____, *Continue to 18*

18. Is the tumor negative for EGFR mutations (e.g., exon 19 deletions or L858R), ALK rearrangements, and ROS1 aberrations? ***ACTION REQUIRED***: *Please attach chart note(s) or test results of EGFR mutations, ALK rearrangements and ROS1 aberrations.*

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, Continue to 20*

❒ No ***ACTION REQUIRED****: Submit supporting documentation, Continue to 24*

❒ Unknown, *Continue to 19*

19. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. What is the clinical setting in which the requested medication will be used?

❒ First-line treatment, *Continue to 21*

❒ Maintenance therapy following first-line cemiplimab-rwlc therapy, *Continue to 23*

❒ Other, please specify. _____, *No further questions*

21. What is the requested regimen?

❒ Single agent, *Continue to 22*

❒ In combination with platinum-based chemotherapy (e.g., cisplatin, carboplatin), *No further questions*

❒ Other, please specify. _____, *No further questions*

22. Does the tumor have high PD-L1 expression [Tumor Proportion Score (TPS) greater than or equal to 50%]?
***ACTION REQUIRED***: *If yes, please attach chart note(s) or test results of programmed death ligand 1 (PD-L1) tumor expression.*

❒ Yes ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ No, *No further questions*

❒ Unknown, *No further questions*

23. What is the requested regimen?

❒ Single agent, *No further questions*

❒ In combination with pemetrexed, *No further questions*

❒ Other, please specify. _____, *No further questions*

24. What is the place in therapy in which the requested medication will be used?

❒ First-line therapy, *Continue to 25*

❒ Subsequent therapy, *Continue to 25*

25. What is the requested regimen?

❒ In combination with platinum-based chemotherapy, *No further questions*

❒ Other, please specify. _____, *No further questions*

26. What is the place in therapy in which the requested medication will be used?

❒ First line therapy, *Continue to 27*

❒ Subsequent therapy, *Continue to 27*

27. What is the clinical setting in which the requested medication will be used?

❒ Advanced disease, *Continue to 28*

❒ Recurrent/metastatic disease, *Continue to 28*

❒ Other, please specify. _____, *Continue to 28*

28. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

29. What is the place in therapy in which the requested medication will be used?

❒ First line therapy, *Continue to 30*

❒ Subsequent therapy, *Continue to 30*

30. What is the clinical setting in which the requested medication will be used?

❒ Recurrent disease, *Continue to 31*

❒ Metastatic disease, *Continue to 31*

❒ Other, please specify. _____, *Continue to 31*

31. Will the requested medication be used as a single agent?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X_____**
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**



**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**