Libtayo

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*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

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

Criteria Questions:

1. What is the diagnosis?
   - ❑ Cutaneous squamous cell carcinoma
   - ❑ Basal cell carcinoma
   - ❑ Non-small cell lung cancer
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Has the patient experienced disease progression while on programmed death receptor-1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitor therapy? ❑ Yes ❑ No
4. Is the patient currently receiving the requested medication? ❑ Yes ❑ No *If No, skip to diagnosis section*
5. Has the patient experienced disease progression or an unacceptable toxicity while receiving the requested drug/regimen? ❑ Yes ❑ No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Cutaneous Squamous Cell Carcinoma

6. How is the patient's disease classified?
   - ❑ Metastatic disease, *skip to #8*
   - ❑ Locally advanced disease, *skip to #8*
   - ❑ Regional disease
   - ❑ Other _____
7. Is the disease inoperable or incompletely resected? ❑ Yes ❑ No
8. Is the patient a candidate for curative surgery or curative radiation?
   ❑ Yes ❑ No *No further questions*

Section B: Basal Cell Carcinoma

9. How is the patient's disease classified?
   - ❑ Metastatic disease
   - ❑ Locally advanced disease
   - ❑ Other _____
10. Has the patient received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo])? ❑ Yes *If Yes, no further questions* ❑ No
11. Is a hedgehog pathway inhibitor appropriate for the patient? ❑ Yes ❑ No *No further questions*

Section C: Non-Small Cell Lung Cancer

12. What is the clinical setting in which the requested drug will be used?
    - ❑ First-line treatment
    - ❑ Subsequent treatment
13. Does the tumor have high PD-L1 expression [Tumor Proportion Score (TPS) $\geq$ 50%]? ***ACTION REQUIRED: Please attach documentation of programmed death ligand 1 (PD-L1) tumor expression.*** ❑ Yes ❑ No ❑ Unknown
14. Does the tumor have EGFR, ALK or ROS1 aberrations? ***ACTION REQUIRED: Please attach documentation of EGFR, ALK, and ROS1 status.*** ❑ Yes ❑ No ❑ Unknown
15. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue? ❑ Yes ❑ No
16. How is the patient's disease classified?
    - ❑ Metastatic disease *No further questions*
    - ❑ Locally advanced disease
    - ❑ Other _____

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17. Is the patient a candidate for surgical resection or definitive chemoradiation? ❑ Yes ❑ No

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)**

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