JOHNS HOPKINS
HEALTH PLANS

Libtayo

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____*Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Criteria Questions:

1. What is the diagnosis?

❒ Cutaneous squamous cell carcinoma (CSCC) (*If checked, go to 2*)
❒ Basal cell carcinoma (BCC) (*If checked, go to 2*)
❒ Non-small cell lung cancer (NSCLC) (*If checked, go to 2*)
❒ Other, please specify. _____ (*If checked, go to 2*)

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

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, *No Further Questions*
❒ No, *Continue to 3*

3. Is the patient currently receiving the requested medication?
❒ Yes, *Continue to 4*
❒ No, *Continue to 5*

4. Has the patient experienced disease progression or an unacceptable toxicity while on the current regimen?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

5. What is the diagnosis?
❒ Cutaneous squamous cell carcinoma (CSCC) (*If checked, go to 6*)
❒ Basal cell carcinoma (BCC) (*If checked, go to 10*)
❒ Non-small cell lung cancer (NSCLC) (*If checked, go to 14*)

6. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease (*If checked, go to 8*)
❒ Locally advanced disease (*If checked, go to 8*)
❒ Recurrent disease (*If checked, go to 8*)
❒ Regional disease (*If checked, go to 7*)
❒ Other, please specify. _____ (*If checked, no further questions*)

7. Is the disease inoperable or incompletely resected?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the patient a candidate for curative surgery or curative radiation?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

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

10. Will the requested medication be used as a single agent?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease (*If checked, go to 12*)
❒ Advanced disease (*If checked, go to 12*)
❒ Recurrent disease (*If checked, go to 12*)
❒ Other, please specify. _____ (*If checked, go to 12*)

12. Has the patient received a hedgehog pathway inhibitor (e.g., vismodegib [Erivedge], sonidegib [Odomzo])?
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

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

14. What is the clinical setting in which the requested medication will be used?
❒ Metastatic disease (*If checked, go to 15*)
❒ Advanced disease (*If checked, go to 15*)
❒ Recurrent disease (*If checked, go to 15*)
❒ Other, please specify. _____ (*If checked, go to 15*)

15. 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 (*If checked, go to 17)*
❒ No, ***ACTION REQUIRED***: Submit supporting documentation (*If checked, go to 22*)
❒ Unknown (*If checked, go to 16*)

16. Is testing for these genomic tumor aberrations not feasible due to insufficient tissue?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the clinical setting in which the requested drug will be used?
❒ First-line treatment (*If checked, go to 18*)
❒ Maintenance therapy (*If checked, go to 20*)
❒ Other, please specify. _____ (*If checked, no further questions*)

18. What is the requested regimen?
❒ Single agent (*If checked, go to 19*)
❒ In combination with platinum-based chemotherapy (e.g., cisplatin, carboplatin) (*If checked, no further questions*)
❒ Other, please specify. _____ (*If checked*, *no further questions*)

19. 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 (*If checked, no further questions*)
❒ No (*If checked, no further questions*)
❒ Unknown (*If checked, no further questions*)

20. Is there tumor response or stable disease following first-line cemiplimab-rwlc therapy?

❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. What is the requested regimen?
❒ Single agent (*If checked*, *no further questions*)
❒ In combination with pemetrexed (*If checked, no further questions*)
❒ Other, please specify. _____ (*If checked, no further questions*)

22. Which of the following biomarkers apply to the patient's disease? ***ACTION REQUIRED***: Please attach chart notes or test results of biomarker testing.
❒ BRAF V600E mutation, NTRK 1/2/3 gene fusion, MET exon 14 skipping mutation, or RET rearrangement (*If checked, go to 26*)
❒ A sensitizing EGFR mutation (e.g., exon 19 deletion, exon 21 L858R, S768I, L861Q or G719X) (*If checked, go to 23*)
❒ An ALK rearrangement (*If checked, go to 24*)
❒ A ROS1 rearrangement (*If checked, go to 25*)
❒ None of the above (*If checked, no further questions*)

23. Has the patient been previously treated with an EGFR inhibitor (e.g., erlotinib, afatinib, gefitinib, osimertinib, dacomitinib)?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

24. Has the patient been previously treated with an ALK inhibitor (e.g., crizotinib, ceritinib, alectinib, brigatinib, lorlatinib)?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

25. Has the patient been previously treated with crizotinib, entrecitinib, or ceritinib?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Will the requested drug be used as subsequent therapy?
❒ Yes, *Continue to 27*
❒ No, *Continue to 27*

27. What is the requested regimen?
❒ In combination with platinum-based chemotherapy (*If checked*, *no further questions*)
❒ Other, please specify. _____ (*If checked, 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)**

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