SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Libtayo® (cemiplimab-rwlc)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 6 months

1. Is the prescriber an oncologist? **AND** ❑ Yes ❑ No
2. Is the member 18 years of age or older? **AND** ❑ Yes ❑ No
3. Does the member have a diagnosis of:
   a. Locally advanced cutaneous squamous cell carcinoma and is not a candidate for curativesurgery or radiation therapy? **OR**
      ❑ Yes ❑ No
   b. Cutaneous squamous cell carcinoma with nodal or distant metastatic disease? **AND**
      ❑ Yes ❑ No

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4. Has the member received previous therapy with the following?
   a. A programmed death (PD-1/PD-L1)-directed therapy (e.g., avelumab, pembrolizumab,atezolizumab, durvalumab, nivolumab, etc.) unless otherwise specified? **OR**

      ❑ Yes ❑ No

   b. A cytotoxic T-lymphocyte antigen 4 (CTLA-4) targeting agent (e.g., ipilimumab, etc.) within theprevious 4 weeks prior to therapy?

      ❑ Yes ❑ No

   c. A BRAF-inhibitor (e.g., vemurafenib, dabrafenib, encorafenib, etc.)?

      ❑ Yes ❑ No

   d. A small-molecule inhibitor (phosphtidylinositol-3 kinase inhibitor [PI3-K]) therapy (e.g.,idelalisib, duvelisib, etc.)?

      ❑ Yes ❑ No

Reauthorization Approval – 6 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

5. Does the member continue to meet the above criteria? **AND** ❑ Yes ❑ No
6. Does the member have absence of unacceptable toxicity from the drug? Examples of unacceptable toxicity include the following: severe infusion reactions, severe immune-mediated adverse reactions such as pneumonitis, colitis, hepatitis, endocrinopathies, nephritis/renal dysfunction, rash, encephalitis, etc.; **AND** ❑ Yes ❑ No
7. Does the member have tumor response with stabilization of disease or decrease in size of tumor or tumor spread? ❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

REVISED/UPDATED/REFORMATTED: ~~2/17/2020;~~ **11/07/2023.**