LIBTAYO SURROUND®

LIBTAYO Surround® Copay Program
Fax cover sheet for claims submissions

Please fill out all fields below.

To: LIBTAYO Surround Copay Program

Fax: 1.833.853.8362

Subject: LIBTAYO Surround copay claims

Date: _____

From: _____

Time: _____

Phone: _____

Pages: _____

Patient's LIBTAYO Surround Copay Program ID number: _____

Patient's initials: _____ Patient's date of birth: _____

Address where the reimbursement check should be mailed:

Name: _____

Street: _____

City: _____ State: _____ ZIP: _____

Comments:

Index the attached CMS 1500 or CMS 1450 form and Explanation of Benefits as a CLAIM to be processed for copay reimbursement.

_____

_____

REGENERON SANOFI GENZYME

LIBTAYO® (cemiplimab-rwlc)
Injection 350 mg