LIBTAYO SURROUND®

Patient Tracking Worksheet

This worksheet is designed to help you and your office staff track the status of your patients' LIBTAYO prescription and keep a record of the communications you receive from your patients' health insurers and LIBTAYO Surround.
You can follow 2 patients per worksheet (1 per side), allowing you to quickly reference their information when needed.

Patient Name (Last, First) ______________________ DOB ____/____/____

☐ LIBTAYO Surround Enrollment Form sent to LIBTAYO Surround   Patient ID ____________   ☐ Male ☐ Female

Payer Name ______________________ Payer Phone ____________

Payer Fax ____________ Payer ID ____________

Prior authorization (PA) status: ☐ Sent to ______________________ on ____/____/____
Health plan contact name

☐ PA approved ☐ PA denied Reason for denial ______________________

Appeal status (if applicable): ☐ Sent to ______________________ on ____/____/____
Health plan contact name

☐ Appeal approved ☐ Appeal denied Reason for denial ______________________

Copay Program status (if applicable): ☐ Submitted to LIBTAYO Surround by ______________________
Office contact name

on ____/____/____ ☐ Patient approved on ____/____/____ ☐ Patient denied on ____/____/____

Reason for denial ______________________

Patient Assistance Program status (if applicable): ☐ Submitted to LIBTAYO Surround by ______________________
Office contact name

on ____/____/____ ☐ Patient approved on ____/____/____ ☐ Patient denied on ____/____/____

Reason for denial ______________________

LIBTAYO order and fulfillment status: ☐ Order for LIBTAYO sent to ______________________ on ____/____/____
Distributor or specialty pharmacy

☐ Order received on ____/____/____

Notes: ______________________

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This blank form is provided for healthcare provider office use.
It may contain sensitive information and should be handled accordingly.

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg

LIBTAYO SURROUND®

Patient Tracking Worksheet (cont'd)

Patient Name (Last, First) ______________________________ DOB ____/____/____

☐ LIBTAYO Surround Enrollment Form sent to LIBTAYO Surround   Patient ID ______________   ☐ Male ☐ Female

Payer Name ______________________________ Payer Phone ______________________

Payer Fax ______________________ Payer ID ______________

Prior authorization (PA) status: ☐ Sent to ______________________________ on ____/____/____
Health plan contact name

☐ PA approved   ☐ PA denied   Reason for denial ______________________________

Appeal status (if applicable): ☐ Sent to ______________________________ on ____/____/____
Health plan contact name

☐ Appeal approved   ☐ Appeal denied   Reason for denial ______________________________

Copay Program status (if applicable): ☐ Submitted to LIBTAYO Surround by ______________________________
Office contact name

on ____/____/____   ☐ Patient approved on ____/____/____   ☐ Patient denied on ____/____/____

Reason for denial ______________________________

Patient Assistance Program status (if applicable): ☐ Submitted to LIBTAYO Surround by ______________________________
Office contact name

on ____/____/____   ☐ Patient approved on ____/____/____   ☐ Patient denied on ____/____/____

Reason for denial ______________________________

LIBTAYO order and fulfillment status: ☐ Order for LIBTAYO sent to ______________________________ on ____/____/____
Distributor or specialty pharmacy

☐ Order received on ____/____/____

Notes: ______________________________

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For any questions or concerns, or to report side effects with a Regeneron and Sanofi product for patients enrolled in LIBTAYO Surround, please contact LIBTAYO Surround at **1.877.LIBTAYO** (1.877.542.8296) **Option 1**, Monday–Friday, 8 AM–8 PM Eastern time.

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