LIBTAYO Surround®

Commercial Copay Program fax cover sheet for claims submissions

Please fill out all fields below.

To: LIBTAYO Surround Commercial Copay Program

Fax: 1.888.381.0939

Subject: LIBTAYO Surround commercial copay claims **Date:** _____

From: _____ **Time:** _____

Phone: _____ **Pages:** _____

Patient's LIBTAYO Surround Commercial 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:** _____

Attach CMS-1500 or UB-04 form and Explanation of Benefits as a CLAIM to be processed for copay reimbursement.

Comments:

_____

_____

REGENERON®

US.LIB.24.01.0025 02/24

LIBTAYO® (cemiplimab-rwlc) Injection 350 mg