Suggestions for Writing a Prior Authorization Request Letter for UNLOXCYT™ (cosibelimab-ipdl)

Most health plans will require prior authorization (PA) for coverage of UNLOXCYT. Since requirements and documentation vary by plan, it is important to review the specific PA guidelines provided by each health plan before submitting a request. The checklist and the sample letter provided here are helpful resources to assist in preparing a complete and accurate PA request.

Before submitting your PA request, confirm that UNLOXCYT is covered under the patient's health plan for the treatment of metastatic cutaneous squamous cell carcinoma or locally advanced cutaneous squamous cell carcinoma. Additionally, ensure all information is complete and accurate—errors and missing information are among the most common reasons for denial. The PA request should be submitted along with relevant medical records and any supporting documentation required by the health plan.

Checklist

- ☐ **Patient Information**: Include the patient's name, date of birth, and insurance policy ID number
- ☐ **Diagnosis Code(s)**: Include specific ICD-10-CM code(s) that align with your patient's diagnosis
- ☐ **Treatment Rationale**: Explain the clinical rationale for treatment with UNLOXCYT and why it is medically necessary for your patient
- ☐ **Medical Documentation**: Include copies of relevant medical records:
  - Patient's history, characteristics (eg, age, comorbidities, and ECOG status), diagnosis (including lesion site[s]), disease staging, disease progression, and prognosis
  - Documentation that the patient is not a candidate for curative surgery or curative radiation
  - Relevant pathology reports, laboratory results, and imaging reports
- ☐ **Treatment History**: List prior therapies, dates they were administered, and the patient's response (or lack thereof)
- ☐ **Supporting Evidence**: Provide evidence such as peer-reviewed literature, clinical trial publications, and the prescribing information for UNLOXCYT, which includes the clinical efficacy and safety profile
- ☐ **Closing Statement**: Summarize your recommendation, and provide a contact number should any additional information be required

ECOG, Eastern Cooperative Oncology Group; ICD-10-CM, *International Classification of Diseases, Tenth Revision, Clinical Modification*.

Sample Prior Authorization Request Letter for UNLOXCYT™ (cosibelimab-ipdl)

[INSERT ON PHYSICIAN LETTERHEAD]

[Date]

[Health plan name]
To/Attn: [Name of prior authorization department]
[Mailing address]
Re: [Patient Name]
DOB: [Date of birth]
Insurance Policy ID number: [Policy ID Number]
Subject: Prior Authorization Request for UNLOXCYT™ (cosibelimab-ipdl)

Dear [Health Plan Contact Name/Medical Director],

This letter is sent on behalf of [Patient's name] to request coverage for UNLOXCYT.

[Patient's name] is a [age]-year-old [male/female] who was diagnosed with [diagnosis] (ICD-10-CM code: [code]) on [date]. The patient is not a candidate for curative surgery or curative radiation therapy. Additional details regarding the patient's medical history, diagnosis, and treatment rationale are provided below.

[Provide a concise summary of the clinical rationale for treatment with UNLOXCYT. Include a brief overview of the patient's medical history and diagnosis, prior treatments (with duration and outcomes), any lack of response or tolerability to alternative therapies, relevant comorbid conditions, and the clinical factors for recommending treatment with UNLOXCYT.]

In my clinical judgment, treatment with UNLOXCYT is appropriate for [Patient's name] and I respectfully request coverage approval. Supporting documentation is enclosed for your review. Please contact my office at [phone number] if additional information is needed.

Sincerely,

[Physician signature]

[Insert name]

Enclosed:

[Attach any additional relevant supporting documentation. List all enclosed documents]