

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 **SANOFI GENZYME** 

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LIB.21.11.0013 11/2021

 **LIBTAYO**
(cemiplimab-rwlc)
Injection 350 mg