SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Cibinqo™ (abrocitinib) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dosage:

- 100 mg orally once daily
- 200 mg orally once daily if not responding to 100 mg daily.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Refractory, Moderate-to-Severe Atopic Dermatitis (Adults)**

Length of authorization: 12 months.

❑ Member is ≥ **12** years of age

AND

(Continued on next page)

- ❑ Trial and failure of Dupixent® (dupilumab)

AND

- ❑ Trial and failure of Adbry® (tralokinumab)

AND

- ❑ Diagnosis of refractory, moderate-to-severe atopic dermatitis

AND

- ❑ Prior documented trial and failure (or contraindication) to the following:
  - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)

AND

  - ❑ One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)

AND

- ❑ Inadequate response to a 3-month minimum trial of at least one immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.)

AND

- ❑ Inadequate response (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc.) provided member has reasonable access to photo treatment

AND

- ❑ Prescriber attestation that Cibinqo will not be used in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****