

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: Cibinco™ (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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

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**
whose disease is not adequately controlled with other systemic drug products, including biologics,
or when use of those therapies is inadvisable.

Length of authorization: 12 months.

- Member is ≥ 12 years of age

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- ❑ Diagnosis of refractory, moderate-to-severe atopic dermatitis
- ❑ Prior documented trial and failure (or contraindication) **BOTH** of the following:
 - ❑ One (1) topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone)
 - ❑ One (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)
- ❑ Inadequate response to a 3-month minimum trial of at least one immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.)
- ❑ 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
- ❑ Prescriber attestation that Cibinqo will not be used in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants
- ❑ Trial and failure of Dupixent[®] (dupilumab)

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.****