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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

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 or older

(Continued on next page)

- ❑ 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 2 preferred agents in the Immunomodulators, Atopic Dermatitis class, with one of those being a systemic agent
- ❑ 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 at least one of the preferred systemic agents below for a minimum of 3 months:

❑ Adbry™	❑ Dupixent®	❑ Ebglyss™

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.*

REVISED/UPDATED/REFORMATTED: ~~6/8/2022; 6/29/2022; 12/27/2022; 3/31/2023; 12/21/2023; 10/17/2025; 1/20/2026;~~ **7/9/2026**