SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Cibinqo® (abrocitinib)

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:** _____

Weight: _____ **Date:** _____

Quantity Limit: 1 tablet per day

Recommended Dosage: 100 mg once daily. 200 mg orally once daily is recommended for those patients who are not responding to 100 mg once 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: Moderate-to-Severe Atopic Dermatitis**

  - ❑ Member has a diagnosis of **moderate to severe atopic dermatitis** with disease activity confirmed by **ONE** of the following **(chart notes documenting disease severity and BSA involvement must be included)**:
    - ❑ Body Surface Area (BSA) involvement >10%
    - ❑ Eczema Area and Severity Index (EASI) score ≥ 16
    - ❑ Investigator's Global Assessment (IGA) score ≥ 3
    - ❑ Scoring Atopic Dermatitis (SCORAD) score ≥ 25

(Continued on next page)

- ❑ Prescribed by or in consultation with an **Allergist, Dermatologist** or **Immunologist**
- ❑ Member is 12 years of age or older
- ❑ Member is **NOT** receiving Cibinqo® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants
- ❑ Member has tried and failed, has a contraindication, or intolerance to **ALL** four of the following therapies **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ 30 days (14 days for very high potency) of therapy with **ONE** medium to very-high potency topical corticosteroid in the past 180 days
  - ❑ 30 days of therapy with **ONE** of the following topical calcineurin inhibitors in the past 180 days:
    - ❑ tacrolimus 0.03 % or 0.1% ointment
    - ❑ pimecrolimus 1% cream (requires prior authorization)
  - ❑ 90 days of phototherapy (e.g., NB UV-B, PUVA) unless the member is not a candidate and/or has an intolerance or contraindication to therapy
  - ❑ 90 days of therapy with **ONE** of the following oral immunosuppressants in the past 180 days:
    - ❑ azathioprine
    - ❑ cyclosporine
    - ❑ methotrexate
    - ❑ mycophenolate

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.*