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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

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

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.

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?

  ❑ Yes **OR** ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

(Continued on next page)

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

- ❑ Prescribed by or in consultation with an **Allergist, Dermatologist** or **Immunologist**
- ❑ Member is 12 years of age or older
- ❑ Member has a diagnosis of **moderate to severe atopic dermatitis** with disease activity confirmed by **ONE** of the following
  - ❑ 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
- ❑ Member is **NOT** receiving Cibinqo® in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants
- ❑ Member has tried and failed at least **TWO** of the following therapies **(check all that apply; verified by chart notes and/or pharmacy paid claims)**:
  - ❑ 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** topical calcineurin inhibitor in the past 180 days (e.g., tacrolimus ointment, pimecrolimus cream*) (***requires prior authorization**)
  - ❑ 30 days of therapy with **ONE** topical phosphodiesterase-4 enzyme inhibitor in the past 180 days (e.g., Eucrisa*, Zoryve 0.15% cream*) **(*requires prior authorization)**
  - ❑ 30 days of therapy with **ONE** topical janus kinase inhibitor in the past 180 days (e.g., Opzelura*) **(*requires prior authorization)**
  - ❑ 90 days of therapy with **ONE** generic oral DMARD (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate mofetil)
- ❑ Member has tried and failed **BOTH** of the following **(verified by chart notes/and or pharmacy paid claims)**:
  - ❑ Dupixent® (dupilumab) *requires prior authorization*
  - ❑ Rinvoq® (Upadacitinib) *requires prior authorization*

Medication being provided by a 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.****