AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Cibinqo

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

Initial Approval

1. Does the beneficiary have a diagnosis of moderate to severe atopic dermatitis? Yes___ No___
2. Does the beneficiary have at least 1 of the following? Yes___ No___ **Please indicate which:** _____
   a. Involvement of at least 10% of body surface area (BSA)
   b. Eczema Area and Severity Index (EASI) score of 16 or more
   c. Investigator's Global Assessment (IGA) score of 3 or more
   d. Scoring Atopic Dermatitis (SCORAD) score of 25 or more
   e. Pruritus Numerical Rating Scale (NRS) score of 4 or more
   f. Incapacitation due to AD lesion location (i.e., head and neck, palms, soles, or genitalia)
3. Is the beneficiary 12 years of age or older? Yes___ No___
4. Has the beneficiary failed to respond adequately to a 3-month minimum trial of topical agents (e.g., corticosteroids, calcineurin inhibitors [e.g., tacrolimus or pimecrolimus], crisaborole), or is not a candidate for topical treatment? Yes___ No___
5. Has the beneficiary failed to respond adequately to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light [PUVA], UVB), or is not a candidate for phototherapy? Yes___ No___
6. Has the beneficiary failed to respond adequately to a 3-month minimum trial of ≥ 1 systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, dupilumab, tralokinumab-ldrm)? Yes___ No___
7. Is the beneficiary at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? Yes___ No___
   7a. If yes, has the beneficiary's individual risks and benefits have been considered prior to initiating or continuing therapy? Yes___ No___
8. Is the beneficiary considered to be at high risk for thrombosis? Yes___ No___
9. Has the beneficiary been evaluated and screened for viral hepatitis prior to initiating treatment in accordance with clinical guidelines? Yes___ No___
10. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
11. Will the beneficiary receive live vaccines during Cibinqo therapy? Yes___ No___
12. Will abrocitinib (Cibinqo) be used in combination with other monoclonal antibody biologics (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tralokinumab)? Yes___ No___
13. Will abrocitinib (Cibinqo) be used in combination with other non-biologic agents (e.g., apremilast, baricitinib, tofacitinib, upadacitinib)? Yes___ No___
14. Will the beneficiary be on concomitant antiplatelet therapies during the first 3 months of treatment? (Note: excludes the use of low-dose aspirin [≤ 81 mg daily]) Yes___ No___
15. Does the beneficiary have severe hepatic impairment (e.g., Child-Pugh C) or severe renal impairment (eGFR < 30 mL/min)? Yes___ No___
16. Will the beneficiary avoid concomitant use with a strong CYP2C19 inhibitors (e.g., amitriptyline, fluconazole, imipramine)? Yes___ No___
    16a. If concomitant use with a strong CYP2C19 inhibitor is unavoidable, will the beneficiary be monitored closely for adverse reaction and/or dose modifications will be implemented? Yes___ No___
17. Will the beneficiary avoid concomitant use with moderate to strong CYP2C19 and CYP2C9 inhibitors (e.g., fluconazole, fluvoxamine, voriconazole)? Yes___ No___
18. Will the beneficiary avoid concomitant use with strong CYP2C19 inducers (e.g., enzalutamide, rifampin) or CYP2C9 inducers (e.g., rifampin, carbamazepine, enzalutamide)? Yes___ No___

Continuation Requests for Cibinqo: (questions 1-18 above and 19-21)

19. While on Cibinqo, has the beneficiary had disease improvement in signs and symptoms compared to baseline in ≥ 1 of the following: pruritus, the amount of surface area involvement, EASI, IGA, SCORAD, and/or NRS? Yes___ No___
    19a. Beneficiary has achieved clear or almost clear skin defined as achievement of an IGA 0/1 or EASI-75 at week 16? Yes___ No___

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

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19b. Beneficiary has had an inadequate response to standard doses of therapy after an adequate trial of ≥ 12 weeks OR beneficiary experienced a disease flare and will require higher dosing? Yes___ No___

19c. Beneficiary requires an increase in dose, in accordance with prescribing information recommended dosages (e.g., up to 200 mg daily)? Yes___ No___

20. Has the beneficiary experienced a myocardial infarction or stroke? Yes___ No___

21. Has the beneficiary experienced any treatment-restricting adverse effects? Yes___ No___

21a. If yes, please describe: _____

_____

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.