AvMed

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 1-305-671-0200.** 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 AvMed #: _____ **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. For insufficient response after 12 weeks, may increase dose to 200 mg once daily; Dosage recommendations for CYP2C19 poor metabolizers: 50 mg once daily. For insufficient response after 12 weeks, may increase dose to 100 mg once daily. For all doses, discontinue treatment if inadequate response is seen after dose increase.

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**

(Continued on next page)

- ❑ 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
- ❑ 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 - PropriumRx

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.****