Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cibinqo (abrocitinib) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Cibinqo (abrocitinib).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

The KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a rheumatologist or dermatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Patient is ≥12 years,
   □ No □ Yes

2. **AND** diagnosis of moderate to severe atopic dermatitis,
   □ No □ Yes

3. **AND** history of failure, contraindication, or intolerance to BOTH of the following topical therapies:
   a. Medium to very-high potency topical steroids
   b. Topical calcineurin inhibitor
   □ No □ Yes

4. **AND** history of failure, inadequate response, contraindication or intolerance to narrow-band short wave ultraviolet B (NB-UV light); history of worsening eczema with sunlight/heat is considered contraindication,
   □ No □ Yes

5. **AND** if patient is ≥18 years, history of inadequate response (after at least 1 month of treatment), intolerance, or contraindication (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease) to systemic immunomodulators (i.e., methotrexate, azathioprine, cyclosporine, or mycophenolate mofetil),
   □ No □ Yes

6. **AND** documented inadequate response (of at least a 4-month trial), intolerance, or contraindication to tralokinumab-(Adbry) or dupilumab (Dupixent)
   □ No □ Yes

For Continuation of Therapy, please respond to <u>additional questions</u> below:

1. Member has documentation of positive clinical response,
   □ No □ Yes

2. **AND** specialist follow-up has occurred in the past 12 months since last review
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**
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