STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

ABROCITINIB

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
ABROCITINIB	CIBINQO	47767		GPI-10 (9027200500)	

GUIDELINES FOR USE

INITIAL CRITERIA (NOTE: FOR RENEWAL CRITERIA SEE BELOW)

1. Does the patient have a diagnosis of refractory, moderate to severe atopic dermatitis and meet **ALL** of the following criteria?
   - The patient is 12 years of age or older
   - Therapy is prescribed by or in consultation with a dermatologist, allergist, or immunologist
   - The patient has atopic dermatitis involving at least 10% of body surface area (BSA) OR atopic dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas
   - The patient has TWO of the following: intractable pruritus, cracking and oozing/bleeding of affected skin, impaired activities of daily living
   - The patient had a trial of or contraindication to ONE preferred agent: Dupixent (dupilumab), Rinvoq (upadacitinib)
   - Cibinqo will NOT be used concurrently with other systemic biologics (e.g., Adbry [tralokinumab-ldrm], Dupixent [dupilumab]) for atopic dermatitis or other JAK inhibitors (e.g., Xeljanz [tofacitinib], topical Opzelura [ruxolitinib]) for any indication

   If yes, continue to #2.
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

2. Does the patient have a trial of or contraindication to **TWO** of the following?
   - High or super-high potency topical corticosteroid (e.g., triamcinolone acetonide, fluocinonide, clobetasol propionate)
   - Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus)
   - Topical PDE-4 inhibitor (e.g., crisaborole)
   - Topical JAK inhibitor (e.g., ruxolitinib)
   - Phototherapy

   If yes, **approve for 6 months by HICL or GPI-10 with a quantity limit of #1 per day.**
   If no, do not approve.
   DENIAL TEXT: See the initial denial text at the end of the guideline.

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ABROCITINIB

INITIAL CRITERIA (CONTINUED)

INITIAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

Our guideline named **ABROCITINIB (Cibinqo)** requires the following rule(s) be met for approval:

A. You have refractory, moderate to severe atopic dermatitis (a type of skin condition)
B. You are 12 years of age or older
C. Therapy is prescribed by or in consultation with a dermatologist (a type of skin doctor), allergist (a type of allergy doctor), or immunologist (a type of immune system doctor)
D. You have atopic dermatitis involving at least 10% of body surface area (BSA) OR atopic dermatitis affecting the face, head, neck, hands, feet, groin, or intertriginous areas (between skin folds, the hands, feet, etc.)
E. You have TWO of the following: intractable pruritus (severe itching), cracking and oozing/bleeding of affected skin, impaired activities of daily living
F. You had a trial of or contraindication (harmful for) to TWO of the following:
    1. High or super-high potency topical corticosteroid (such as triamcinolone acetonide, fluocinonide, clobetasol propionate)
    2. Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus)
    3. Topical PDE-4 inhibitor (Phosphodiesterase-4 Inhibitors such as crisaborole)
    4. Topical Janus kinase (JAK) inhibitor (Janus kinase inhibitor such as ruxolitinib)
    5. Phototherapy (light therapy)
G. You had a trial of or contraindication (harmful for) to ONE preferred medication: Dupixent (dupilumab), Rinvoq (upadacitinib)
H. You will NOT use Cibinqo concurrently (at the same time) with other systemic biologics (such as Adbry [tralokinumab-ldrm], Dupixent [dupilumab]) for atopic dermatitis or other Janus kinase (JAK) inhibitors (such as Xeljanz [tofacitinib], topical Opzelura [ruxolitinib]) for any indication

Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

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STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

ABROCITINIB

RENEWAL CRITERIA

1. Does the patient have a diagnosis of refractory, moderate to severe atopic dermatitis and meet **ALL** of the following criteria?
   - The patient has shown improvement while on therapy
   - The patient had a trial of or contraindication to ONE preferred agent: Dupixent (dupilumab), Rinvoq (upadacitinib)
   - Cibinqo will NOT be used concurrently with other systemic biologics (e.g., Adbry [tralokinumab-ldrm], Dupixent [dupilumab]) for atopic dermatitis or other JAK inhibitors (e.g., Xeljanz [tofacitinib], topical Opzelura [ruxolitinib]) for any indication

   If yes, **approve for 12 months by HICL with a quantity limit of #1 per day.**
   If no, do not approve.
   RENEWAL DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

   Our guideline named **ABROCITINIB (Cibinqo)** requires the following rule(s) be met for renewal:
   A. You have refractory, moderate to severe atopic dermatitis (a type of skin condition)
   B. You have shown improvement while on therapy
   C. You had a trial of or contraindication (harmful for) to ONE preferred medication: Dupixent (dupilumab), Rinvoq (upadacitinib)
   D. You will NOT use Cibinqo concurrently (at the same time) with other systemic biologics (such as Adbry [tralokinumab-ldrm], Dupixent [dupilumab]) for atopic dermatitis or other Janus kinase (JAK) inhibitors (such as Xeljanz [tofacitinib], topical Opzelura [ruxolitinib]) for any indication

   Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE

For further information, please refer to the Prescribing Information and/or Drug Monograph for Cibinqo.

REFERENCES

- Cibinqo [Prescribing Information]. New York, NY: Pfizer Labs; February 2023.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/23
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P&T Approval: 07/23