Mountain Pacific
INNOVATING BETTER HEALTH
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Montana Healthcare Programs Prior Authorization Request Form for Use of Cibinqo® (abrocitinib)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ **INITIATION OF THERAPY**

1. Member has a diagnosis of refractory moderate to severe atopic dermatitis: ☐ Yes ☐ No
2. Member is 12 years of age or older: ☐ Yes ☐ No
3. Medication is prescribed by or in consultation with a dermatologist: ☐ Yes ☐ No

   Action required: If not in a specialty clinic or written by a specialist, copy of annual specialty consult with an appropriate specialist is required (please attach copy of consult):

   Name of specialist: _____ **Contact date:** _____
4. Member has clinical documentation of **functional impairment** due to atopic dermatitis, which may include but is not limited to limitations to activities of daily living (ADLs), such as skin infections or sleep disturbances, and a baseline assessment has been made to allow for documentation of positive clinical response: ☐ Yes ☐ No
5. Member must have had an inadequate treatment response, intolerance or contraindication to **all** of the following.

   A preferred high-potency topical corticosteroid: ☐ Yes ☐ No

   Name: _____ **Dates:** _____

   A topical immunomodulator (tacrolimus or pimecrolimus): ☐ Yes ☐ No

   Name: _____ **Dates:** _____

   Another biologic with preferable safety profile (i.e., Dupixent®): ☐ Yes ☐ No

   Name: _____ **Dates:** _____

   NOTE: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids).

6. Provider attests the member will not use Cibinqo® concomitantly with other biologics: ☐ Yes ☐ No
7. Provider attests they have reviewed the black box warning: ☐ Yes ☐ No

Limitations:
Maximum daily dose: 200mg per day

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

1. Member has documentation of positive clinical response to Cibinqo® therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool): ☐ Yes ☐ No
2. Annual specialist consult attached if prescriber is not a specialist: ☐ Yes ☐ No ☐ N/A – Prescriber is specialist.
3. Provider attests the member will not use Cibinqo® concomitantly with other biologics: ☐ Yes ☐ No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments, and fax to Drug Prior Authorization Unit at 1-800-294-1350.

10/2023