



4/2/2026
Prior Authorization
Internal Use Only
JOHNS HOPKINS HEALTH PLANS Cibinqo - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at 1-410-424-4607 . Please contact Johns Hopkins Health Plans at 1-888-819-1043 with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Cibinqo - Priority Partners MCO.

Drug Name (select from list of drugs shown) Cibinqo (abrocitinib)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

Diagnosis: _____	ICD Code: _____
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Comments: _____

Please circle the appropriate answer for each question.	
1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If yes, skip to question 12.]	
2. Does the patient have a confirmed diagnosis of refractory moderate to severe chronic atopic dermatitis with documented body surface area (BSA) coverage of 10 percent or greater?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
3. Does the patient have documented functional impairment as a result of chronic atopic dermatitis, which can include limitation of activities of daily living (e.g., consistent sleep disturbances, problems wearing clothing, skin infections, etc.)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
4. Has documentation been provided showing a baseline assessment using one of the following tools: A) Investigator's Static Global Assessment (ISGA) score, B) Eczema Area and Severity Index (EASI), C) Patient-Oriented Eczema Measure (POEM), OR D) Scoring Atopic Dermatitis (SCORAD) index?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
5. Does the patient have a documented history of treatment failure, contraindication, or intolerance to both of the following formulary alternatives: A) two medium to very-high potency topical corticosteroids, or B) one topical calcineurin inhibitor (e.g., Elidel [pimecrolimus] or Protopic [tacrolimus])?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
6. Does the patient have moderate disease?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, skip to question 8.]	
7. Has the patient had a documented trial and adequate response to Eucrisa (crisaborole)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
8. Is the patient being concomitantly treated with additional biologic medications (Enbrel, Xolair, Rituxan, etc.) for the treatment of atopic dermatitis?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
9. Is the patient 12 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If no, no further questions.]	

10. Will the requested drug be used concurrently with other janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
11. Will the requested drug be used for any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
12. Is there documentation of positive clinical response to therapy and evidence of a score reduction using ONE of the following clinical evaluation tools: A) Investigator's Static Global Assessment (ISGA) decrease from baseline by at least 2 points, B) Eczema Area and Severity Index (EASI) decrease from baseline by at least 75 percent, C) Patient-Oriented Eczema Measure (POEM) decrease from baseline by at least 3 points, OR D) Scoring Atopic Dermatitis (SCORAD) index decrease from baseline by at least 50 percent?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Will the requested drug be used concurrently with other janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
14. Will the requested drug be used for any indications or uses that are not Food and Drug Administration (FDA)-approved or guideline-supported?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
15. Is the patient less than 12 years of age?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date