Prior Authorization Request Form for
abrocitinib **(Cibinqo)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 12 months. Renewal PA criteria will be approved indefinitely. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Cibinqo.*	☐ **Yes** (subject to verification) **proceed to question 2**	☐ **No proceed to question 3**
2. For atopic dermatitis, has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ **Yes** (subject to verification) **Sign and date below**	☐ **No STOP Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ **Yes proceed to question 4**	☐ **No STOP Coverage not approved**
4. Is the requested medication prescribed by a dermatologist, allergist, or immunologist?	☐ **Yes proceed to question 5**	☐ **No STOP Coverage not approved**
5. What is the indication or diagnosis?	☐ Moderate to severe atopic dermatitis- **proceed to question 6** ☐ **Other - STOP Coverage not approved**	

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6. Provider acknowledges that the requested medication is to be used for disease that is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.	☐ **Acknowledged** **proceed to question 7**	
7. Does the patient have a contraindication to, intolerability to, or have they failed treatment with ONE medication in EACH of the following four categories? • **Topical Corticosteroids: high potency/class 1 topical corticosteroids (for example, clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)** • **Topical calcineurin inhibitor (for example, pimecrolimus, tacrolimus)** • **Injectable interleukin antagonist: dupilumab (Dupixent)** • **Oral Janus kinase (JAK) Inhibitors: upadacitinib (Rinvoq)**	☐ **Yes** **proceed to question 8**	☐ **No** **STOP** **Coverage not approved**
8. Does the patient have a contraindication to, intolerability to, inability to access treatment, or has failed treatment with Narrowband UVB phototherapy?	☐ **Yes** **proceed to question 9**	☐ **No** **STOP** **Coverage not approved**
9. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ **Yes** **proceed to question 10**	☐ **No** **STOP** **Coverage not approved**
10. Does the patient have history of venous thromboembolic (VTE) disease?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 11**
11. Is the provider aware of the FDA safety alerts AND Boxed Warnings?	☐ **Yes** **proceed to question 12**	☐ **No** **STOP** **Coverage not approved**
12. Does the patient have evidence of neutropenia (ANC less than 1000)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 13**
13. Does the patient have evidence of lymphocytopenia (ALC less than 500)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 14**
14. Does the patient have evidence of anemia (Hgb less than 8)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 15**

15. Is the patient taking concomitant JAK inhibitors (for example, Xeljanz, Olumiant, Cibinqo)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 16**
16. Is the patient taking concomitant immunosuppressants (for example, azathioprine, cyclosporine)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **proceed to question 17**
17. Is the patient taking concomitant biologic immunomodulators (for example, Humira, Dupixent, Adbry)?	☐ **Yes** **STOP** **Coverage not approved**	☐ **No** **Sign and date below**

STEP 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

Prescriber Signature _____ Date _____

[08 March 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: