



Cibinqo (abrocitinib)

Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

| MEMBER INFORMATION | | |
|------------------------------|----------------|-----------|
| LAST NAME: | FIRST NAME: | |
| PHONE NUMBER: | DATE OF BIRTH: | |
| STREET ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| PATIENT INSURANCE ID NUMBER: | | |

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

| PRESCRIBER INFORMATION | | |
|-------------------------------------------|------------------------|-----------|
| LAST NAME: | FIRST NAME: | |
| PRESCRIBER SPECIALTY: | EMAIL ADDRESS: | |
| NPI NUMBER: | DEA NUMBER: | |
| PHONE NUMBER: | FAX NUMBER: | |
| STREET ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| REQUESTOR (if different than prescriber): | OFFICE CONTACT PERSON: | |

| MEDICATION OR MEDICAL DISPENSING INFORMATION | | | |
|----------------------------------------------|----------------------------------|-------------------------------------|-----------|
| MEDICATION NAME: | | | |
| DOSE/STRENGTH: | FREQUENCY: | LENGTH OF THERAPY/REFILLS: | QUANTITY: |
| <input type="checkbox"/> NEW THERAPY | <input type="checkbox"/> RENEWAL | IF RENEWAL: DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

Continued on next page.





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| | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|
| 1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO | | |
| MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): | DURATION OF THERAPY (SPECIFY DATES): | RESPONSE/REASON FOR FAILURE/ALLERGY: |
| 2. LIST DIAGNOSES: <input type="checkbox"/> Moderate to severe atopic dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____ | | ICD-10: |
| 3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION. | | |
| Clinical Information: Is the drug going to be used in conjunction with a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No <u>Initial Request:</u> Is the prescriber a dermatologist or an allergist? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had the diagnosis of atopic dermatitis for at least 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Does the patient have atopic dermatitis on at least 10% or more of their body surface area? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Has the patient tried at least two different topical steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND one topical calcineurin inhibitor (tacrolimus or pimecrolimus)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> If patient has not had at least 2 different topical steroids, has the patient tried at least one topical steroid AND Eucrisa(crisaborole)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Has patient had a 3-month trial with Dupixent(dupilumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Does patient have an absolute contraindication to Dupixent(dupilumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Has patient had a 3-month trial with Adbry(tralokinumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Does patient have an absolute contraindication to Adbry(tralokinumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please submit documentation.</i> Will Cibinqo(abrocitinib) be used in combination with another JAK inhibitor such as Xeljanz(tofacitinib), Olumiant(baracitinib), RinvoqER(upadacitinib) or Opzelura(ruxolitinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No Will Cibinqo(abrocitinib) be used in combination with Dupixent(dupilumab) or Adbry(tralokinumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |





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Renewal Request:

Is patient continuing to have a positive clinical response? Yes No **Please submit documentation.*

Is the prescriber a dermatologist or an allergist? Yes No

Will Cibinqo(abrocitinib) be used in combination with another JAK inhibitor such as Xeljanz(tofacitinib), Olumiant(baracitinib), RinvoqER(upadacitinib) or Opzelura(ruxolitinib)? Yes No

Will Cibinqo(abrocitinib) be used in combination with another JAK inhibitor such as Xeljanz(tofacitinib), Olumiant(baracitinib), RinvoqER(upadacitinib) or Opzelura(ruxolitinib)? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

***Please note:** Not all drugs/diagnoses are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP - 4201
P.O. Box 64811
St. Paul, MN 55164-0811

