Louisiana Medicaid
Abrocitinib (Cibinqo™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for abrocitinib (Cibinqo™).

Additional Point-of-Sale edits may apply.

*This agent may have **Black Box Warnings** and/or may be subject to **Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety Regulations. Please refer to individual prescribing information for details.*

Approval Criteria

- The recipient is 12 years of age or older on the date of the request; **AND**
- The following is true and is **stated on the request**:
    - The recipient has refractory, moderate to severe atopic dermatitis; **AND**
    - The recipient has a contraindication to, documented intolerance or treatment failure with an adequate trial (6-12 weeks) of **ONE** conventional systemic treatment, including biologics; **AND**
    - There has been a treatment failure or intolerable side effect with or contraindication to a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency); **AND**
    - The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
    - The dose does not exceed 200mg per day; **AND**
    - The agent is not being given in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants; **AND**
    - The recipient has a platelet count $\geq 150{,}000/mm^3$, an ALC ≥ 500 cells/mm^3, an ANC $\geq 1{,}000$ cells/mm^3, and hemoglobin level ≥ 8 g/dL; **AND**
- There is no preferred alternative that is exactly the same chemical entity, formulation, strength, etc.; **AND**
- **ONE** of the following is true and is **stated on the request**
    - The recipient had documented *intolerable side effects* or a documented *treatment failure* with an adequate trial (6-12 weeks) of **TWO** preferred agents, if the preferred agents are indicated for the specified diagnosis; **OR**
    - The recipient has a *contraindication* to the preferred agents indicated for the specified diagnosis; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The recipient will not receive the requested medication in combination with any other cytokine or CAM antagonist; **AND**
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**

- All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
- The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not receive the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Duration of initial approval: 6 months

Reauthorization Criteria

- Recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to treatment as indicated by improvement in signs and symptoms compared to baseline, or by halting of disease progression (no progression of disease signs and symptoms as compared to baseline).

Duration of reauthorization approval: 12 months

References

Cibinqo (abrocitinib) [package insert]. New York, NY: Pfizer Inc; January 2022. https://cdn.pfizer.com/pfizercom/USPI_Med_Guide_CIBINQO_Abrocitinib_tablet.pdf

Megna M, Napolitano M, Patruno C, et al. Systemic Treatment of Adult Atopic Dermatitis: A Review. *Dermatol Ther (Heidelb)*. 2017;7(1):1-23. doi:10.1007/s13555-016-0170-1

Revision / Date	Implementation Date
Policy Created / April 2022	October 2022