PRIOR AUTHORIZATION REQUEST

Cibinqo

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Atopic Dermatitis (If checked, go to 2) [] Other (If checked, no further questions)		
2	Will the patient be concurrently using the requested medication with a biologic or with a targeted synthetic Disease-Modifying Antirheumatic Drug (DMARD)? [If yes, no further questions.]	Yes	No
3	Will the patient be concurrently using the requested medication with an anti-interleukin monoclonal antibody (such as, Dupixent or Adbry)? [If yes, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Will the patient be concurrently using the requested medication with other janus kinase inhibitors (such as, Rinvoq, Xeljanz/XR, Olumiant)? [If yes, no further questions.]	Yes	No
5	Will the patient be concurrently using the requested medication with Xolair (omalizumab subcutaneous injection)? [If yes, no further questions.]	Yes	No
6	Will the patient be concurrently using the requested medication with other potent immunosuppressants (such as, azathioprine, cyclosporine, or mycophenolate)? [If yes, no further questions.]	Yes	No
7	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
8	Is the patient currently receiving the requested medication? [If no, skip to question 15.]	Yes	No
9	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 15.]	Yes	No
10	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 14.]	Yes	No
11	Has the patient already received at least 90 days of therapy with the requested medication? [If no, skip to question 15.]	Yes	No
12	Has documentation been submitted to confirm that the patient has experienced a beneficial clinical response, defined as improvement from baseline (prior to initiating the requested medication) in at least one of the following: A) Estimated body surface area affected, B) Erythema, C) Induration/papulation/edema, D) Excoriations, E) Lichenification, F) A decreased requirement for other topical or systemic therapies for atopic dermatitis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that when compared with baseline (prior to initiating the requested medication), the patient has experienced an improvement in at least one symptom, such as decreased itching or scratching? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No

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14	Has documentation been provided to confirm that the clinical response of the patient's condition has improved compared to baseline? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
16	Has documentation been submitted to confirm that the patient has a diagnosis of refractory, moderate to severe atopic dermatitis involving GREATER THAN OR EQUAL TO 10 percent of the body surface area according to the prescriber? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 18.]	Yes	No
17	Has documentation been submitted to confirm that the patient has affected areas that are of the face, eyes/eyelids, skin folds, and/or genitalia? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
18	Has documentation been submitted to confirm that the patient has had a trial of at least two medium, medium-high, high, or super high potency topical corticosteroids unless intolerant, contraindicated, or unless treating the face/eyes/eyelid areas? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or treatment failure after at least 3 months with Dupixent (dupilumab)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
20	Has the patient tried a topical calcineurin inhibitor for at least 28 consecutive days and inadequate efficacy was demonstrated? [If no, no further questions.]	Yes	No
21	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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maryland physicians care
Medicaid with a Heart

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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