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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with other Biologics or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? [Note: Examples of biologics include but are not limited to adalimumab SC	Yes	No

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	products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic Disease-Modifying Antirheumatic Drugs include, but are not limited to, Cibinqo, Olumiant, Rinvoq, Xeljanz, Xeljanz XR.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	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 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? [Note: Examples of a response are 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 or 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 ? [No further questions.]	Yes	No
8	Will the requested medication be used in combination with other Biologics or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? [Note: Examples of biologics include but are not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic Disease-Modifying Antirheumatic Drugs include, but are not limited to, Cibinqo, Olumiant, Rinvoq, Xeljanz, Xeljanz XR.] [If yes, no further questions.]	Yes	No

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9	What is the diagnosis or indication? [] Atopic Dermatitis (If checked, go to 10) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
11	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 13.]	Yes	No
12	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
13	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
14	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
15	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
16	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
17	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing: 100 mg once daily. For insufficient response, may increase dose to 200 mg once daily.]	Yes	No

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

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.

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