STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J. Mayer
Cabinet Secretary

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Commissioner

Office of Pharmacy Services
Prior Authorization Criteria
Cibinqo® (abrocitinib)
Effective 11/13/2024
Prior Authorization Request Form

Cibinqo *(abrocitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of adults with refractory, moderate-to-severe atopic dermatitis whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.*

CRITERIA FOR APPROVAL:

1. Prescribed by or in consultation with an allergist, immunologist, or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected body surface area (BSA) of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the Food and Drug Administration (FDA) label and indication; **AND**

4. Affected BSA is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

    a. Medium to High potency topical corticosteroid*
    b. Elidel
    c. Eucrisa
    d. Tacrolimus

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds, or genitals. However, a trial of two other agents among the list above, is still required prior to Cibinqo approval.

Approval Duration: Initial approval will be for 3 months.

Criteria for reauthorization:

1. Demonstrate continued documented compliance; **AND**
2. Documentation of satisfactory patient response (including current affected BSA and severity of symptoms) has been provided.

Continuation of therapy will be granted for 12 months.