

Alex J. Mayer, PhD, MS, PMP
Cabinet Secretary

Cynthia Beane, MSW, LCSW
Commissioner

**Office of Pharmacy Services
Prior Authorization Criteria
Cibinqo® (abrocitinib)
Effective 11/19/2025**

[Prior Authorization 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. Must be prescribed by a M.D./D.O. or a specialty trained prescriber with a clinical specialty certification/degree in allergy, immunology, or dermatology; **AND**
2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected body surface area (BSA), areas 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 body surface area 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

*A 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, are still required prior to Cibinqo approval.

Approval Duration: Initial approval will be granted for 3 months.

Criteria for reauthorization:

1. Demonstrated 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.

