Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine & cell-adhesion molecule (CAM) Antagonists: abrocitinib (CIBINQO)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:
1. Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Does the member have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

11. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes
  (Go to #12)
- ◯ No (Deny)
  (Go to #12)

12. Has the member had 30 continuous days of therapy with at least one (1) systemic agent for the treatment of atopic dermatitis in the last 90 days?

    Examples of systemic agents include: azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), dexamethasone, dupilumab (DUPIXENT), hydrocortisone (CORTEF), methylprednisolone (MEDROL), methotrexate (OTREXUP, TREXALL, XATMEP), mycophenolate (CELLCEPT), mycophenolic acid (MYFORTIC), prednisolone (MILLIPRED, VERIPRED), and prednisone.

- ◯ Yes
  (Go to #14)
- ◯ No, and this is a renewal request
  (Go to #14)
- ◯ No, and this is an initial request
  (Go to #13)

13. Has the member had an inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis? [MANUAL]

- ◯ Yes
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

14. Will the member have concurrent therapy with a Janus kinase (JAK) inhibitor, biologic disease-modifying antirheumatic drug (DMARD) or potent immunosuppressant?

Examples of JAK inhibitors include: baricitinib (OLUMIANT), ruxolitinib (JAKAFI), tofacitinib (XELJANZ), and upadacitinib (RINVOQ).

Examples of biologic DMARDs include: abatacept (ORENCIA), adalimumab (HUMIRA), anakinra (KINERET), apremilast (OTEZLA), brodalumab (SILIQ), canakinumab (ILARIS), certolizumab (CIMZIA), etanercept (ENBREL), golimumab (SIMPONI), guselkumab (TREMFYA), ixekizumab (TALTZ), sarilumab (KEVZARA), secukinumab (COSENTYX), tocilizumab (ACTEMRA), and ustekinumab (STELARA).

Examples of potent immunosuppressants include: azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), mycophenolate (CELLCEPT), mycophenolic acid (MYFORTIC), and tacrolimus (ASTAGRAF XL, PROGRAF).

◯ Yes (Deny)
(Go to #15)

◯ No
(Go to #15)

15. Has the member had therapy with a moderate to strong inhibitors of both CYP2C19 and CYP2C9, strong CYP2C19 inducers or strong CYP2C9 inducers in the last 90 days?

Examples of CYP2C19 and CYP2C9 inducers and inhibitors include: fluconazole (DIFLUCAN), fluoxetine (PROZAC), fluvoxamine, olanzapine/fluoxetine (SYMBYAX), and rifampin (RIFADIN).

◯ Yes (Deny)
(Go to #16)

◯ No
(Go to #16)

16. Does the member have a diagnosis of severe hepatic impairment or severe renal impairment [eGFR less than (<) 30 mL/min] in the last 365 days?

◯ Yes (Deny)
(Go to #17)

◯ No
(Go to #17)

17. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Does the member have a diagnosis of mild to moderate renal impairment in the last 365 days?

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #19)

19. Is the member a poor CYP2C19 metabolizer? [Manual]

- ◯ Yes
  (Go to #21)
- ◯ No
  (Go to #20)

20. Is the requested dose less than or equal to (≤) one (1) tablet daily?

- ◯ Yes (Approve - 365 days)
  (Go to #22)
- ◯ No - Deny
  (Go to #21)

21. Is the requested dose less than or equal to (≤) the maximum recommended dose?

- Mild Renal Impairment (eGFR 60-89 mL/min): one (1) 100mg tablet daily
- Moderate Renal Impairment (eGFR 30-59 mL/min): one (1) 50mg tablet daily
- Use with a strong CYP2C19 Inhibitor: one (1) 100mg tablet daily
- CYP2C19 Poor Metabolizer: one (1) 100mg tablet daily

- ◯ Yes (Approve - 365 days)
  (Go to #22)
- ◯ No (Deny)
  (Go to #22)

Additional Information

22. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Customer Care at 877-908-6023

For questions, please call Navitus Customer Care at 1-877-908-6023.