	Johns Hopkins HealthCare LLC Pharmacy Public Pharmacy Management Drug Policies	<i>Policy Number</i>	MEDS148
		<i>Effective Date</i>	04/20/2022
		<i>Review Date</i>	04/20/2022
		<i>Revision Date</i>	04/20/2022
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This document applies to the following Participating Organizations:

Priority Partners

Keywords: Cibinqo


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I. POLICY

- A. Cibinqo (abrocitinib) will require prior authorization for appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.
- PPMCO members are subject to the Priority Partners formulary, available at www.ppmco.org.
 - USFHP members are subject to prior authorization criteria, step-edits and days-supply limits outlined in the Tricare Policy Manual. Tricare Policy supersedes JHHC Medical/Pharmacy Policies. Tricare limits may be accessed at: http://pec.ha.osd.mil/formulary_search.php?submenuheader=1

II. POLICY CRITERIA

- A. **Cibinqo** may be approved for patients meeting the following:
- Moderate-to-Severe Atopic Dermatitis**
 - Patient is 18 years of age or older
 - Documentation has been submitted showing the following:
 - Patient has a confirmed diagnosis of refractory moderate to severe chronic atopic dermatitis with documented BSA coverage of 10% or greater
 - Patient has documented functional impairment as a result of chronic atopic dermatitis, which can include limitation of activities of daily living (ex. consistent sleep disturbances, problems wearing clothing, skin infections, etc.)
 - Documentation has been provided showing a baseline assessment using one of the following tools:
 - Investigator's Static Global Assessment (ISGA) score
 - Eczema Area and Severity Index (EASI)
 - Patient-Oriented Eczema Measure (POEM)
 - Scoring Atopic Dermatitis (SCORAD) index
 - Patient has documented history of treatment failure, contraindication, or intolerance to both of the following formulary alternatives:
 - Two medium to very-high potency topical corticosteroids
 - One topical calcineurin inhibitor [ex. Elidel (pimecrolimus) or Protopic (tacrolimus)]
 - Caveat for patients with moderate disease:

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- i. In addition to trials of topical corticosteroids and a calcineurin inhibitor, documentation of trial and inadequate response to Eucrisa (crisaborole) is required.
- e. Patient is not being concomitantly treated with additional biologic medication (Enbrel, Xolair, Rituxan, etc.) for the treatment of atopic dermatitis
- f. Cibinqo is being prescribed by one of the following specialists:
 - I. Allergist
 - II. Dermatologist
 - III. Immunologist

III. AUTHORIZATION PERIOD/LIMITATIONS

- A. Initial approval will be limited to 6 months of therapy
- B. Approval for continuation of therapy may be extended in 12-month intervals with documentation of positive clinical response to therapy, and evidence of a score reduction using ONE of the following clinical evaluation tools:
 1. ISGA: decrease from baseline by at least 2 points
 2. EASI: decrease from baseline by at least 75%
 3. POEM: decrease from baseline by at least 3 points
 4. SCORAD: decrease from baseline by at least 50%

IV. EXCLUSIONS

- A. Cibinqo will not be approved for the following:
 1. Pediatric patients
 2. Concurrent use with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants
 3. Any indications or uses that are FDA-approved, or guideline-supported
- B. The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

V. REFERENCES

1. Cibinqo [prescribing information]. New York, NY: Pfizer Inc.; January 2022.
2. Simpson EL, Sinclair R, Forman S, et al. Efficacy and safety of abrocitinib in adults and adolescents with moderate-to-severe atopic dermatitis (JADE MONO-1): a multicentre, double-blind, randomised, placebo-controlled, phase 3 clinical trial. *Lancet*. 2020;396:255-266.
3. Eichenfield LF, Tom WL, Chamlin SL, et. al. Guidelines of care for the management of atopic dermatitis: Section 1. Diagnosis and assessment of atopic dermatitis. *J Am Acad Dermatol*. 2014;70:338-51.
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VI. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
04/20/2022	Policy Creation

Review Date: 04/20/2022

Revision Date:

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