Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: Cibinqo™ (abrocitinib)

Effective: February 13, 2024

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Cibinqo (abrocitinib) is a Janus kinase (JAK) inhibitor indicated for:

- **Atopic dermatitis**
  For the treatment of adults and pediatric patients 12 years of age or older 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 not advisable. Cibinqo is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Clinical Guideline Coverage Criteria

The plan may authorization coverage of Cibinqo for Members when all of the following criteria are met:

Initial Authorization Criteria

1. Documented diagnosis of moderate to severe atopic dermatitis

AND

2. Documentation the patient's condition meets **one (1)** of the following:
   a. Body Surface Area (BSA) of at least 10%
   b. Eczema Area and Severity Index EASI score of at least 16
   c. Investigator's Global Assessment/Physician Global Assessment (IGA/PGA) score of at least 3

AND

3. Patient is at least 12 years of age

AND

4. Prescribed by or in consultation with a dermatologist, allergist, or immunologist

AND

5. Documentation of **one (1)** of the following:
   a. Inadequate response or adverse reaction to one (1) of the following: a medium or high potency topical corticosteroid, a calcineurin inhibitor, or crisaborole
   b. Contraindication to all of the following: medium and high potency topical corticosteroids, topical calcineurin inhibitors, and crisaborole

AND

6. Documentation of **one (1)** of the following:
    a. Inadequate response or adverse reaction following a minimum 12-week supply of one (1) systemic drug product for the treatment of atopic dermatitis (e.g., Adbry Dupixent)
    b. Contraindication to all systemic drug products for the treatment of atopic dermatitis

Reauthorization Criteria

1. Documented diagnosis of moderate to severe atopic dermatitis

AND

2. Patient is at least 12 years of age

AND

3. Prescribed by or in consultation with a dermatologist, allergist, or immunologist

AND

4. Documentation the patient has experienced a therapeutic response as defined by **one (1)** of the following:
    a. Reduction in body surface area involvement relative to pretreatment baseline
    b. Improvement in atopic dermatitis symptoms as evidenced by marked improvements in symptoms such as pruritus, xerosis, crusting, or lichenification
    c. Reduction in the use of other topical or systemic therapies

Limitations

1. Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinical inappropriateness to methotrexate therapy.
2. Initial approval of Cibinqo will be authorized for six (6) months. Reauthorization of Cibinqo will be provided in 12-month intervals.
3. Patients new to the plan stable on Cibinqo should be reviewed against Reauthorization Criteria.

Codes

None

References

1. Cibinqo (abrocitinib) [prescribing information]. New York, NY: Pfizer Inc.; December 2023.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

1. March 14, 2023: Expanded age requirements to at least 12 years of age to be in line with updated package labeling (effective 4/1/23).
2. February 13, 2024: No changes

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.