

CIBINQO

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Moderate-to-severe atopic dermatitis (AD) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ 3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindications: _____ 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., dermatologist, allergist, immunologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Has the patient been tested for latent tuberculosis (TB)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the patient test positive for latent tuberculosis (TB)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, has the patient begun therapy for latent TB? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the patient's age within FDA labeling for the requested indication for the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ 7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibinqo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Enbrel (etanercept), Entyvio (vedolizumab), Fasenra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlectinib), Nemludio (nemolizumab-ilty), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Ustekinumab products, Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]?..... Yes No

If yes, please specify agent: _____

If yes, does the prescribing information for the requested agent limit the use with another immunomodulatory agent? Yes No

If no, is there support for the use of combination therapy? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required.**..... Yes No

For moderate-to-severe atopic dermatitis (AD) requests:

9. Does the patient have at least 10% body surface area involvement? Yes No

10. Does the patient have involvement of body sites that are difficult to treat with prolonged topical corticosteroid therapy (e.g., hands, feet, face, neck, scalp, genitals/groin, skin folds)?..... Yes No

11. Does the patient have an Eczema Area and Severity Index (EASI) score greater than or equal to 16? Yes No

12. Does the patient have an Investigator Global Assessment (IGA) score greater than or equal to 3? Yes No

13. Is the patient currently treated with topical emollients and practicing good skin care? Yes No

If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No

14. Has the patient tried and had an inadequate response to ONE at least medium-potency topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of AD?..... Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids used in the treatment of AD?..... Yes No

If yes, please specify FDA labeled contraindications: _____

15. Has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy?..... Yes No

If no, has the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD?..... Yes No

If yes, please specify FDA labeled contraindications: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>16. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of AD? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify agent: _____</p>			
<p>For renewal requests:</p> <p>17. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>For renewal moderate-to-severe atopic dermatitis (AD) requests:</p> <p>18. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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