



Cibinqo Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date

04-01-2026

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Cibinqo	abrocitinib tab	100 MG ; 200 MG ; 50 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Cibinqo	Abrocitinib Tab	50 MG	30	Tablets	30	DAYS			
Cibinqo	Abrocitinib Tab	100 MG	30	Tablets	30	DAYS			
Cibinqo	Abrocitinib Tab	200 MG	30	Tablets	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Cibinqo	abrocitinib tab	100 MG ; 200 MG ; 50 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Cibinqo	Abrocitinib Tab	50 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Cibinqo	Abrocitinib Tab	200 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Cibinqo	Abrocitinib Tab	100 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL HMO Performance Quarterly ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval		
	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The requested agent is eligible for continuation of therapy AND the following: <table border="1" data-bbox="235 646 950 724"> <tr> <td>Agents Eligible for Continuation of Therapy</td> </tr> <tr> <td>All target agents are eligible for continuation of therapy</td> </tr> </table> B. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed OR B. BOTH of the following: <ol style="list-style-type: none"> 1. ONE of the following: <ol style="list-style-type: none"> A. The patient has at least 10% body surface area involvement OR B. The patient has 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) OR C. The patient has an Eczema Area and Severity Index (EASI) score greater than or equal to 16 OR D. The patient has an Investigator Global Assessment (IGA) score greater than or equal to 3 AND 2. ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The patient has ONE of the following: <ol style="list-style-type: none"> A. Has 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 OR B. Has an intolerance or hypersensitivity to ONE at least medium-potency topical corticosteroid used in the treatment of AD OR C. Has an FDA labeled contraindication to ALL medium-, high-, and super-potency topical corticosteroids used in the treatment of AD AND 2. The patient has ONE of the following: <ol style="list-style-type: none"> A. Has tried and had an inadequate response to ONE topical 	Agents Eligible for Continuation of Therapy	All target agents are eligible for continuation of therapy
Agents Eligible for Continuation of Therapy			
All target agents are eligible for continuation of therapy			

Module	Clinical Criteria for Approval
	<p>calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy OR</p> <p>B. Has an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD OR</p> <p>C. Has an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD OR</p> <p>B. The patient’s medication history (excluding sample use) indicates 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 for the treatment of AD OR</p> <p>B. The patient has another FDA labeled indication for the requested agent and route of administration AND</p> <p>2. If the patient has an FDA labeled indication, then ONE of the following:</p> <p>A. The patient’s age is within FDA labeling for the requested indication for the requested agent OR</p> <p>B. There is support for using the requested agent for the patient’s age for the requested indication OR</p> <p>C. The patient has another indication that is supported in compendia for the requested agent and route of administration AND</p> <p>2. If the patient has a diagnosis of moderate-to-severe atopic dermatitis (AD), then BOTH of the following:</p> <p>A. The patient is currently treated with topical emollients and practicing good skin care AND</p> <p>B. The patient will continue the use of topical emollients and good skin care practices in combination with the requested agent AND</p> <p>3. The patient has been tested for latent tuberculosis (TB) AND if positive the patient has begun therapy for latent TB AND</p> <p>4. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., dermatologist, allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis AND</p> <p>5. ONE of the following (please refer to “Agents NOT to be used Concomitantly” table):</p> <p>A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) OR</p> <p>B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:</p> <p>1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent AND</p> <p>2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) AND</p> <p>6. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Compendia Allowed: AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

Module	Clinical Criteria for Approval
	<p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p>Renewal Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] AND 2. The patient has had clinical benefit with the requested agent AND 3. If the patient has a diagnosis of moderate-to-severe atopic dermatitis, the patient will continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent AND 4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, allergist, immunologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND 5. ONE of the following (please refer to "Agents NOT to be used Concomitantly" table): <ol style="list-style-type: none"> A. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) OR

Module	Clinical Criteria for Approval
	<p>B. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following:</p> <ol style="list-style-type: none"> 1. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent AND 2. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) AND <p>6. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit <p>Length of Approval: 12 months</p>

CONTRAINDICATION AGENTS

Contraindicated as Concomitant Therapy
<p>Agents NOT to be used Concomitantly</p> <p>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)</p>

Contraindicated as Concomitant Therapy

Dupixent (dupilumab)
Ebglyss (lebrikizumab-lbkz)
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)
Imuldosa (ustekinumab-srlf)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Leqselvi (deuruxolitinib)
Litfulo (ritlecitinib)
Nemluvio (nemolizumab-ilto)
Nucala (mepolizumab)
Olumiant (baricitinib)
Omlyclo (omalizumab-igec)
Omvoh (mirikizumab-mrkz)
Opzelura (ruxolitinib)
Orencia (abatacept)
Otezla (apremilast)
Otezla XR (apremilast extended-release)
Otulfi (ustekinumab-aaaz)
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
Velsipity (etrasimod)
Wezlana (ustekinumab-auub)
Xeljanz (tofacitinib)

Contraindicated as Concomitant Therapy

Xeljanz XR (tofacitinib extended release)
Xolair (omalizumab)
Yesintek (ustekinumab-kfce)
Yuflyma (adalimumab-aaty)
Yusimry (adalimumab-aqvh)
Zeposia (ozanimod)
Zymfentra (infliximab-dyyb)