AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Cibinqo (abrocitinib)	Page:	1 of 6
Effective Date:	5/23/2025	Last Review Date:	4/2025

Applies to:	☐Illinois	☐Florida	☒Florida Kids
	☒New Jersey	☒Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Cibinqo under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications[1]

Cibinqo is indicated for the treatment of adults and pediatric patients 12 years of age and 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 inadvisable.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Cibinqo

Policy/Guideline:

Documentation for all indications:
The patient is unable to take Dupixent and Rinvoq, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests

- Chart notes or medical record documentation showing affected area(s) and affected body surface area (where applicable).
- Chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy (where applicable).

Continuation requests

Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialties

This medication must be prescribed by or in consultation with a dermatologist or allergist/immunologist.

Coverage Criteria

Atopic Dermatitis[1-4,7]

Authorization of 4 months may be granted for members 12 years of age or older for treatment of moderate-to-severe atopic dermatitis when the member has had an inadequate response or intolerance to at least one biologic (e.g., Adbry, Dupixent, Ebglyss, Nemluvio) or a systemic targeted synthetic drug (e.g., Rinvoq) in the past year.

Authorization of 4 months may be granted for treatment of moderate-to-severe atopic dermatitis in members 12 years of age or older when all of the following criteria are met:

- Affected body surface is greater than or equal to 10% body surface area OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
- Member meets either of the following:
    - Member has had an inadequate treatment response with one of the following in the past year:
        - A medium potency to super-high potency topical corticosteroid (see Appendix)
        - A topical calcineurin inhibitor
        - A topical Janus kinase (JAK) inhibitor
        - A topical phosphodiesterase-4 (PDE-4) inhibitor
    - The use of medium potency to super-high potency topical corticosteroid, topical calcineurin inhibitor, topical JAK inhibitor, and topical PDE-4 inhibitor are not advisable for the member (e.g., due to contraindications, prior intolerances).
- Member has had an inadequate response or intolerance to treatment with a biologic (e.g., Adbry, Dupixent, Ebglyss, Nemluvio) or systemic targeted synthetic drug (e.g., Rinvoq) indicated for the treatment of atopic dermatitis.

Continuation of Therapy[1,3]

Authorization of 12 months may be granted for members 12 years of age or older (including new members) who are using the requested medication for moderate-to-severe atopic dermatitis when the member has achieved or maintained a positive clinical response as

evidenced by low disease activity (i.e., clear or almost clear skin), or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting).

Other[1,5]

Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA]) within 12 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

Member cannot use the requested medication concomitantly with any other biologic drug, targeted synthetic drug, or potent immunosuppressant such as azathioprine or cyclosporine.

Approval Duration and Quantity Restrictions:

Approval:

- **Initial:** 4 months
- **Renewal:** 12 months

Quantity Level Limit:
30 tablets per 30 days

Appendix:
Table. Relative potency of select topical corticosteroid products

Potency	Drug	Dosage form	Strength
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2

Potency	Drug	Dosage form	Strength
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
Potency	**Drug**	**Dosage form**	**Strength**
III. High potency (group 3)	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%

Potency	Drug	Dosage form	Strength
		Aerosol Spray	0.2 mg per 2-second spray
V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%
	Desonide	Cream, Lotion, Foam	0.05%
	Fluocinolone acetonide	Cream, Solution, Shampoo, Oil	0.01%
	Triamcinolone acetonide	Cream, lotion	0.025%
VII. Least potent (group 7)	Hydrocortisone (base, greater than or equal to 2%)	Cream, Ointment, Solution	2.5%
		Lotion	2%
	Hydrocortisone (base, less than 2%)	Cream, Ointment, Gel, Lotion, Spray, Solution	1%
		Cream, Ointment	0.5%
	Hydrocortisone acetate	Cream	2.5%
		Lotion	2%
		Cream	1%

References:

1. Cibinqo [package insert]. New York, NY: Pfizer Inc.; December 2023.

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.
4. Sidbury R, Alikhan A, Bercovitch L, et. al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023;89(1):e1-e20.
5. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on November 15, 2024 from: https://www.cdc.gov/tb/testing/index.html.
6. Topical Corticosteroids. Drug Facts and Comparisons. Facts & Comparisons [database online]. St. Louis, MO: Wolters Kluwer Health Inc; July 18, 2024. Accessed November 9, 2024.
7. Davis DMR, Drucker AM, Alikhan A, et al. Guidelines of care for the management of atopic dermatitis in adults with phototherapy and systemic therapies. J Am Acad Dermatol. 2024 Feb;90(2):e43-e56.