BlueCross BlueShield Federal Employee Program

CIBINQO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Cibinqo (abrocitinib)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

How many tablets will the patient need for a 90 day supply? _____ tablet(s) per 90 days

1. What is the patient's diagnosis?
   - ❑ Atopic dermatitis (eczema)
   - ❑ Other diagnosis ***(please specify)***: _____
2. Has the prescriber considered the risks for malignancy and major adverse cardiovascular events (MACE) (such as advanced age, smoking history, cardiovascular risk factors etc.) and determined that Cibinqo therapy is appropriate? ❑Yes ❑No
3. Does the patient have any active bacterial, invasive fungal, viral, or other opportunistic infections present? ❑Yes ❑No
4. Will the patient be given live vaccines while on Cibinqo? ❑Yes ❑No
5. Will Cibinqo be used in combination with another *****non-topical Prior Authorization (PA) medication for atopic dermatitis? ❑Yes***** ❑No
   ****If YES***, please specify medication: _____
   ****Non-Topical PA Medications: Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Rinvoq (upadactinib)***
6. Has the patient been on Cibinqo continuously for the last **3 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have moderate to severe atopic dermatitis (eczema)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least **TWO** systemic atopic dermatitis medications, including biologics (e.g., oral corticosteroids, hydroxyzine, Adbry, Dupixent, Rinvoq, etc)? ❑Yes ❑No

c. Has the patient been tested for latent tuberculosis (TB)? ❑Yes***** ❑No

****If YES***, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*****

****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

d. Does the patient have severe hepatic impairment (Child-Pugh Class C)? ❑Yes ❑No

e. Does the patient have a lymphocyte count less than 500 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No

f. Does the patient have an absolute neutrophil count (ANC) less than 1000 cells per cubic millimeter (cells/mm3)? ❑Yes ❑No

g. Does the patient have a hemoglobin less than 8 grams per deciliter (g/dL)? ❑Yes ❑No

h. Does the patient have a history of thrombotic events including deep vein thrombosis (DVT) or pulmonary embolism (PE)? ❑Yes ❑No

i. Will Cibinqo be used in combination with antiplatelet therapy during the first three months of treatment (excluding low-dose aspirin less than or equal to 81 mg daily)? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

b. Has the patient developed any thrombotic events, including deep vein thrombosis (DVT) or pulmonary embolism (PE)? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Cibinqo – FEP MD Fax Form Revised 9/16/2022

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

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