Cibinqo

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the prescribed dose and frequency?
   - ❑ Cibinqo 50mg Quantity and Frequency: _____
   - ❑ Cibinqo 100mg Quantity and Frequency: _____
   - ❑ Cibinqo 200mg Quantity and Frequency: _____
   - ❑ Other _____
2. What is the diagnosis?
   - ❑ Atopic dermatitis, moderate-to-severe
   - ❑ Other _____
3. What is the ICD-10 code? _____
4. Will the requested drug be used in combination with any other biologic (e.g., Adbry, Dupixent) or targeted synthetic disease-modifying anti-rheumatic drug (DMARD) (e.g., Rinvoq), or potent immunosuppressants such as azathioprine or cyclosporine? ❑ Yes ❑ No
5. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Rinvoq) associated with an increased risk of tuberculosis? *If Yes, skip to #9* ❑ Yes ❑ No
6. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy? ❑ Yes ❑ No
7. What were the results of the tuberculosis (TB) test? ❑ Positive for TB ❑ Negative for TB ❑ Unknown
8. Which of the following applies to the patient?
   - ❑ Patient has latent TB and treatment for latent TB has been initiated
   - ❑ Patient has latent TB and treatment for latent TB has been completed
   - ❑ Patient has latent TB and treatment for latent TB has not been initiated
   - ❑ Patient has active TB
9. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #12*

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #12*

11. Has the patient 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) since starting treatment with the requested medication? ***ACTION REQUIRED: If Yes, please attach supporting documentation (e.g. chart notes) showing that the patient has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms.*** *If Yes, skip to #18* ❑ Yes ❑ No *If No, no further questions.*

12. What is the percentage of body surface area (BSA) affected prior to initiation of the requested medication? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s) or medical record indicating affected area(s) and body surface area. _____%*** *If greater than or equal to 10% of BSA, skip to #14*

13. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record or claims history showing prerequisite therapies, including response to therapy.*** ❑ Yes ❑ No

14. Has the patient had an inadequate response to treatment with a topical corticosteroid or topical calcineurin inhibitor? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history showing prerequisite therapies, including response to therapy.*** *If Yes, skip to #16* ❑ Yes ❑ No

15. Is the use of topical corticosteroids and topical calcineurin inhibitors not advisable for the patient? ***ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.*** ❑ Yes ❑ No

16. Has the patient had an inadequate response to treatment with a systemic drug product (e.g., oral cyclosporine, azathioprine, methotrexate, mycophenolate mofetil), or a biologic (e.g., dupilumab, tralokinumab-ldrm), indicated for the treatment of atopic dermatitis? ***ACTION REQUIRED: If Yes, please attach supporting chart note(s), medical record documentation, or claims history showing prerequisite therapies, including response to therapy and skip to #18.*** ❑ Yes ❑ No

17. Is the use of other systemic drug products (e.g., oral cyclosporine, azathioprine, methotrexate, mycophenolate mofetil), including biologics (e.g., dupilumab, tralokinumab-ldrm), not advisable for the patient? ***ACTION REQUIRED: If Yes, please attach supporting documentation of why therapy is not advisable.*** ❑ Yes ❑ No

18. Is the patient currently receiving the requested drug? ❑ Yes ❑ No *If No, no further questions.*

19. Is this a request for a change in dosing regimen? ❑ Yes ❑ No *If No, no further questions.*

20. Does the patient require an increased dose due to an inadequate response at the current dose? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155