UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1382-5
Program	Prior Authorization/Notification
Medication	Cibinqo® (abrocitinib) tablets
P&T Approval Date	3/2022, 3/2023, 3/2024, 4/2025, 4/2026
Effective Date	7/1/2026

1. Background:

Cibinqo is a Janus kinase (JAK) inhibitor 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.

Limitation of Use:
Cibinqo is not recommended in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

2. Coverage Criteria[a]:

A. Atopic Dermatitis

1. **Initial Authorization**

a. **Cibinqo** will be approved based on **all** of the following criteria:

(1) Diagnosis of moderate-to-severe chronic atopic dermatitis

-AND-

(2) History of failure, contraindication, or intolerance to at least **one** systemic drug product for the treatment of atopic dermatitis

-AND-

(3) Patient is not receiving Cibinqo in combination with **any** of the following for treatment of the same indication:

(a) Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto)]
(b) Janus kinase inhibitor [e.g., Olumiant (baricitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]
(c) Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

Authorization will be issued for 12 months.

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2. **Reauthorization**

a. **Cibinqo** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cibinqo therapy

-AND-

(2) Patient is not receiving Cibinqo in combination with **any** of the following for treatment of the same indication:

(a) Biologic immunomodulator [e.g., Adbry (tralokinumab-ldrm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Nemluvio (nemolizumab-ilto)]
(b) Janus kinase inhibitor [e.g., Olumiant (baricitinib), Opzelura (topical ruxolitinib), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib)]
(c) Potent immunosuppressant (e.g., azathioprine, cyclosporine, mycophenolate mofetil)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity, and/or Step Therapy may be in place.

4. References:

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

Program	Prior Authorization/Notification – Cibinqo (abrocitinib)
Change Control	
3/2022	New program
3/2023	Annual review. Updated background and criteria to reflect expanded indication for patients 12 years of age and older. Updated reference. Added state mandate footnote.
3/2024	Annual review. Removed age requirement from criteria. Updated reference.
4/2025	Annual review with no changes to coverage criteria. Updated examples with no change to clinical intent.
4/2026	Annual review. Updated combination use language with no change to clinical intent.

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