Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Cibinqo

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____ 4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Reauthorization Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial Authorization Request:

1. Does the member have a diagnosis of moderate-to-severe atopic dermatitis (AD) defined by ≥ 1 of the following
   - ☐ Involvement of ≥ 10% of body surface area (BSA); OR
   - ☐ Eczema Area and Severity Index (EASI) score of ≥ 16; OR
   - ☐ Investigator's Global Assessment (IGA) score of ≥ 3; OR
   - ☐ Scoring Atopic Dermatitis (SCORAD) score of ≥ 25; OR
   - ☐ Pruritus Numerical Rating Scale (NRS) score of ≥ 4; OR
   - ☐ Incapacitation due to AD lesion location (head and neck, palms, soles, or genitalia)? ☐ **Yes** ☐ **No**
2. Is the member 12 years of age or older? ☐ **Yes** ☐ **No**
3. Has the member NOT responded adequately (or is not a candidate) to a 3-month minimum trial of topical agents (e.g., corticosteroids, calcineurin inhibitors [e.g., tacrolimus or pimecrolimus], crisaborole)? ☐ **Yes** ☐ **No**
4. Has the member NOT responded adequately (or is not a candidate) to a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light [PUVA}, UVB)? ☐ **Yes** ☐ **No**
5. Has the member NOT responded adequately (or is not a candidate) to a 3-month minimum trial of ≥ 1 systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, dupilumab, and/or tralokinumab-ldrm)? ☐ **Yes** ☐ **No**
6. Has the member's individual risks and benefits been considered prior to initiating or continuing therapy in those at higher risk for malignancy and/or major adverse cardiovascular events (MACE)? ☐ **Yes** ☐ **No**
7. Is member NOT considered to be at high risk for thrombosis? ☐ **Yes** ☐ **No**
8. Has the member been evaluated and screened for the presence of viral hepatitis prior to initiating treatment in accordance with clinical guidelines? ☐ **Yes** ☐ **No**
9. Has the member been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
10. Will the member NOT receive live vaccines during therapy ☐ **Yes** ☐ **No**
11. Will the medication not be used in combination with other monoclonal antibody biologics (e.g., Tezepelumab, omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tralokinumab) or other non-biologic agents (e.g., apremilast, baricitnib, tofacitinib, Upadacitinib)? ☐ **Yes** ☐ **No**
12. Will the member avoid concomitant therapy with all of the following:
    - ☐ Coadministration with strong CYP2C19 inhibitors (e.g., amitriptyline, fluconazole, imipramine), if therapy is unavoidable, will the member be monitored closely for adverse reaction and/or dose modifications implement?
    - ☐ Coadministration with strong CYP2C19 and CYP2C9 inhibitors (e.g., fluconazole, fluvoxamine, voriconazole),
    - ☐ Coadministration with strong CYP2C19 inducers (e.g., enzalutamide, rifampin) or CYP2C9 inducers (e.g., rifampin, carbamazepine, enzalutamide)? ☐ **Yes** ☐ **No**

Criteria for Renewal:
Member must continue to meet the above criteria

1, Has the member's disease responded as indicated by improvement in signs and symptoms compared to baseline in ≥ 1 of the following: pruritus, the amount of surface area involvement, EASI, IGA, SCORAD, and/or NRS; ☐ **Yes** ☐ **No LIST**_____**AND (please check below response)**

- Member has achieved clear or almost clear skin defined as achievement of an IGA 0/1 or EASI-75 at week 16; **OR**
- Member has had an inadequate response to standard doses of therapy after an adequate trial of ≥ 12 weeks **OR** has Member experienced a disease flare and will require higher dosing; **AND**
- Member requires an increase in dose, in accordance with prescribing information recommended dosages

2. Has the member NOT experienced a myocardial infarction or stroke; ☐ **Yes** ☐ **No**
3. Has the member NOT experienced any treatment-restricting adverse effects (serious infections [fungal, viral, or other opportunistic infections], tuberculosis, virus reactivation [e.g., herpes zoster, Hepatitis B, Hepatitis C), malignancy and lymphoproliferative disorders [e.g., lymphomas, non-melanoma skin cancer, or other solid tumors], major adverse cardiovascular events [MACE], thrombosis [e.g., pulmonary embolism, deep vein thrombosis, arterial thrombosis], lymphopenia, thrombocytopenia, neutropenia, anemia, lipid elevation, etc.). ☐ **Yes** ☐ **No**

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.