Mass General Brigham
Health Plan

Cibinqo (abrocitinib)
Effective 01/01/2027

Plan	☐ MassHealth UPPL ☒ Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Cibinqo (abrocitinib) is a Janus kinase (JAK) inhibitor indicated for the treatment of adult 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.

Coverage Guidelines
If member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), submission of medical records documenting that the member is currently receiving treatment with the requested drug, excluding when the product is obtained as samples or via manufacturer's patient assistance programs.
OR
Authorization may be granted for members when all of the following criteria are met:

1. Member is 12 years of age or older
2. Diagnosis of refractory, moderate to severe atopic dermatitis
3. 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.
4. Member has had trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), intolerance, or contraindication to at least ONE of the following:
    a. Medium or higher potency topical corticosteroid
    b. Pimecrolimus cream
    c. Tacrolimus ointment
    d. Eucrisa
5. Trial and failure, intolerance, or contraindication with one of the following:
    a. Adbry
    b. Dupixent
    c. Ebglyss
    d. Nemluvio

Continuation of Therapy

Requests for reauthorization will be approved when all of the following criteria are met:

1. Submission of medical records (e.g., chart notes) demonstrating a clinical improvement in the member's condition, as evidenced by low disease activity (e.g., clear or almost clear skin), or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting)

Limitations

1. Initial authorizations will be granted for 6 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

Drug Name and Dosage Form	Quantity Limit
Cibinqo 50 mg, 100 mg 200 mg tablet	1 tablet per day

Appendix

Appendix: Relative potency of select topical corticosteroid products

Potency	Drug	Dosage form	Strength
Super-high potency	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
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
High potency	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%
High potency	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%

Potency	Drug	Dosage form	Strength
	Triamcinolone acetonide	Cream, Ointment	0.5%
Medium potency	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%
		Aerosol Spray	0.2 mg per 2-second spray

References

1. Cibinqo (abrocitinib) [prescribing information]. New York, NY: Pfizer Inc.; December 2023.

Review History

06/22/2022 – Created and reviewed for June P&T. Effective 10/10/2022
11/15/2023 – Reviewed and Updated for Nov P&T; Removed TB requirement. Effective 1/1/24
01/08/2025 – Reviewed and updated for January P&T. Updated approvable age from 18 to 12 years to align with updated package labeling. Updated diagnosis criteria to require refractory disease, as specified in the package insert. Updated topical step through requirements to include Eucrisa and added minimal trial length. Updated criteria to require step through with either Adbry or Dupixent. Updated reauthorization criteria to require documentation of improvement in the member's clinical condition. Removed from initial and reauthorization criteria that Cibinqo will not be used with other biologics or immunosuppressants. Effective 04/01/2025.
02/12/2025 – Reviewed and updated for February P&T. Updated approval length to 24 months. Effective 04/01/2025.
03/12/2025 – Reviewed and updated for March P&T. Updated approval length to 6 months initial and 12 months on reauthorization. Effective 04/01/2025.
04/09/2025 – Reviewed and updated for April P&T. Added Ebglyss as a systemic step through option. Effective 07/01/2025.
02/11/2026 – Reviewed at February P&T. No clinical changes. Effective 03/01/2026.
03/11/2026 – Reviewed and updated for March P&T. Administrative update - changing verbiage in reauthorization criteria from "documentation is submitted" to "submission of medical records (e.g., chart notes…" and updating language for members who are new to the Plan. Effective 05/01/2026.
04/15/2026 – Reviewed and updated for April P&T. Updated atopic dermatitis criteria to remove "at least" from the trial requirements of Dupixent, Adbry or Eblgyss. Effective 08/16/2026.
09/09/2026 – Reviewed and updated at September P&T. Added Nemluvio as a previous trial biologic option. Effective 01/01/2027.