

Cibinco (abrocitinib)
Effective 07/01/2025

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> 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

Cibinco (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

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted for members when all the following criteria are met:

1. Member is 12 years of age or older
2. Member has a 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. Member has had trial and failure, intolerance, or contraindication with at least one of the following:
 - a. Adbry
 - b. Dupixent
 - c. Ebglyss

Continuation of Therapy

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

1. Documentation has been submitted supporting 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
Cibinql 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%
High potency	Halobetasol propionate	Lotion	0.01%
	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%
	Triamcinolone acetonide	Cream, Ointment	0.5%
	Betamethasone dipropionate	Spray	0.05%



Potency	Drug	Dosage form	Strength
Medium potency	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.

