Clinical Policy: Abrocitinib (Cibinqo)

Reference Number: CP.PHAR.578
Effective Date: 06.01.22
Last Review Date: 11.25
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Abrocitinib (Cibinqo®) is a Janus kinase (JAK) inhibitor.

FDA Approved Indication(s)

Cibinqo is indicated for the treatment of adults and pediatric patients 12 years of age and older with refractory, moderate-to-severe atopic dermatitis (AD) whose disease is not adequately controlled with other systemic drug products, including biologics, or when use of those therapies is inadvisable.

Limitation(s) of use: Cibinqo is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, or with other immunosuppressants.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Cibinqo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Atopic Dermatitis (must meet all)**:**

1. Diagnosis of AD affecting one of the following (a or b):
   a. At least 10% of the member's body surface area (BSA);
   b. Hands, feet, face, neck, scalp, genitals/groin, and/or intertriginous areas;
2. Prescribed by or in consultation with a dermatologist or allergist;
3. Age ≥ 12 years;
4. Failure of both of the following (a and b), unless contraindicated or clinically significant adverse effects are experience:
   a. Two formulary medium to very high potency topical corticosteroids, each used for ≥ 2 weeks;
   b. One non-steroidal topical therapy* used for ≥ 4 weeks: topical calcineurin inhibitor (e.g., tacrolimus 0.03% ointment, pimecrolimus 1% cream) or Eucrisa®;
   **These agents may require prior authorization*
5. Cibinqo is not prescribed concurrently with another biologic immunomodulators (e.g., Adbry™, Dupixent®) or a JAK inhibitor (e.g., Olumiant®, Rinvoq®, Cibinqo®, Opzelura™);

6. Dose does not exceed one of the following (a or b):
   a. Both of the following (i and ii):
      i. 100 mg per day;
      ii. One tablet per day;
   b. Medical justification supports inadequate response to 100 mg daily after 12 weeks and both of the following (i and ii):
      i. 200 mg per day;
      ii. One tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Atopic Dermatitis (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by, including but not limited to, reduction in itching and scratching;
3. Cibinqo is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Dupixent) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
4. Dose does not exceed one of the following (a or b):
   a. Both of the following (i and ii):
      i. 100 mg per day;
      ii. One tablet per day;
   b. Medical justification supports inadequate response to 100 mg daily after 12 weeks and both of the following (i and ii):
      i. 200 mg per day;
      ii. One tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
AD: atopic dermatitis
BSA: body surface area
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Very High Potency Topical Corticosteroids		
augmented betamethasone 0.05% (Diprolene® AF) cream, ointment, gel, lotion	Apply topically to the affected area(s) BID	Varies
clobetasol propionate 0.05% (Temovate®) cream, ointment, gel, solution		
diflorasone diacetate 0.05% (Maxiflor®, Psorcon E®) cream, ointment		
halobetasol propionate 0.05% (Ultravate®) cream, ointment		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
High Potency Topical Corticosteroids		
diflorasone 0.05% (Florone®, Florone E®, Maxiflor®,Psorcon E®) cream	Apply topically to the affected area(s) BID	Varies
fluocinonide acetonide 0.05% (Lidex®, Lidex E®) cream, ointment, gel, solution		
triamcinolone acetonide 0.5% (Aristocort®, Kenalog®) cream, ointment		
Medium Potency Topical Corticosteroids		
desoximetasone 0.05% (Topicort ®) cream, ointment, gel	Apply topically to the affected area(s) BID	Varies
fluocinolone acetonide 0.025% (Synalar®) cream, ointment		
mometasone 0.1% (Elocon®) cream, ointment, lotion		
triamcinolone acetonide 0.025%, 0.1% (Aristocort®, Kenalog®) cream, ointment		
Low Potency Topical Corticosteroids		
alclometasone 0.05% (Aclovate®) cream, ointment	Apply topically to the affected area(s) BID	Varies
desonide 0.05% (Desowen®) cream, ointment, lotion		
fluocinolone acetonide 0.01% (Synalar®) solution		
hydrocortisone 2.5% (Hytone®) cream, ointment		
Other Classes of Agents		
Protopic® (tacrolimus), Elidel® (pimecrolimus)	Children ≥ 2 years and adults: Apply a thin layer topically to affected skin BID. Treatment should be discontinued if resolution of disease occurs.	Varies
Eucrisa® (crisaborole)	Apply a thin layer topically to the affected areas BID	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): Antiplatelet therapies except for low-dose aspirin (≤ 81 mg daily), during the first 3 months of treatment.
- Boxed warning(s): serious infections, mortality, malignancy, major adverse cardiovascular events, and thrombosis

Appendix D: General Information

- Topically applied corticosteroids and emollients are the main stay of therapy for atopic dermatitis. Topical immunosuppressant calcineurin inhibitors are next used if topical steroids are not adequate.
- In moderate to severe AD, systemic options such as oral immunosuppressants or biologics may be used after failure of topical therapies. Oral JAK inhibitors are indicated for refractory moderate to severe AD whose disease is not adequately controlled with other systemic agents, including biologics.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Moderate-to-severe AD	100 PO QD 200 mg orally once daily is recommended for those patients who are not responding to 100 mg once daily	200 mg/day

VI. Product Availability

Tablet: 50 mg, 100 mg, and 200 mg

VII. References

1. Cibinqo. Prescribing Information. New York, NY: Pfizer Inc.; December 2023. Available at https://www.cibinqo.com/. Accessed April 15, 2025.
2. Eichenfield F, Tom WL, Chamlin SL, et al. Guidelines of Care for the Management of Atopic Dematitis. *J Am Acad Dermatol*. 2014 February; 70(2): 338–351.
3. Clinical Review Report: Dupilumab (Dupixent): Sanofi-Aventis Canada Inc. Indication: Moderate-to-severe atopic dermatitis (AD) Ottawa (ON): Canadian Agency for Drugs and Technologies in Health; 2018 Jul. Appendix 5, Validity of Outcomes Measures. Available from https://www.ncbi.nlm.nih.gov/books/NBK539234/.
4. Drucker AM, Ellis AG, Bohdanowicz M, et al. Systemic Immunomodulatory Treatments for Patients with Atopic Dermatitis: A Systematic Review and Network Meta-analysis. *JAMA Dermatol*. 2020;156(6):659-667. doi:10.1001/jamadermatol.2020.0796.
5. Clinical Pharmacology [database online]. Philadelphia, PA: Elsevier; 2025. Available at: https://www.clinicalkey.com/pharmacology/. Accessed May 20, 2025.
6. Sidbury R, Alikhan A, Bercovitch L, et al. Guidelines of care for the management of atopic dermatitis in adults with topical therapies. J Am Acad Dermatol. 2023 Jul;89(1):e1-e20. doi: 10.1016/j.jaad.2022.12.029.
7. Davis DMR, Drucker AM, Alikhan A, et al. Guidelines of care for the management of atopic dermatitis in adults with phototherapy and systemic therapies. J Am Acad Dermatol. 2023 Nov 3:S0190-9622(23)02878-5. doi: 10.1016/j.jaad.2023.08.102.

8. Chu DK, Schneider L, Asiniwasis RN, et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma, and Immunology Joint Task Force on Practice Parameters GRADE- and Institute of Medicine-based recommendations. Ann Allergy Asthma Immunol. 2023 Dec 18:S1081-1206(23)01455-2. doi: 10.1016/j.anai.2023.11.009.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.02.22	05.22
3Q 2022 annual review: no significant changes; added length requirement "after 12 weeks" to initial criteria 6b and continuation of therapy criteria 4b to clarify when 200 mg maximum dose is appropriate; references reviewed and updated.	07.26.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.19.22	
RT4: updated criteria to reflect pediatric extension to age ≥ 12 years	02.15.23	
3Q 2023 annual review: no significant changes; updated methotrexate maximum dosing in Appendix B to align with other bDMARD policies; removed informational EASI score and IGA scale in Appendix E and Appendix F since criteria does not require objective scoring; references reviewed and updated.	04.27.23	08.23
For initial criteria, removed systemic immunosuppressant therapy step criterion per updated guideline and competitor analysis; for Appendix B, removed systemic immunosuppressant therapy therapeutic alternatives.	01.18.24	02.24
3Q 2024 annual review: no significant changes; for Appendix D, updated therapeutic options with place in therapy per current guidelines; references reviewed and updated.	05.13.24	08.24
3Q 2025 annual review: no significant changes; references reviewed and updated.	04.15.25	08.25
Per August SDC, removed Commercial and HIM line of business; extended initial approval duration from 6 months to 12 months.	08.20.25	11.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.