

## Cibinqo

### Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.**

**1. Patient information**
**2. Physician information**

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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**3. Medication**
**4. Strength**
**5. Directions**
**6. Quantity per 30 days**

Cibinqo			Specify:
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**7. Diagnosis:**

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of refractory, moderate to severe atopic dermatitis (AD) in the last 730 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had 30 continuous days of therapy with at least one systemic agent for the treatment of atopic dermatitis in the last 90 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the client had inadequate response or intolerance to systemic agents for the treatment of atopic dermatitis?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will the client have concurrent therapy with a JAK inhibitor, biologic DMARD, or potent immunosuppressant?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of severe hepatic impairment or severe renal impairment (eGFR < 30 ml/min) in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does the client have a diagnosis of mild to moderate renal impairment in the last 365 days?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the client a poor CYP2C19 metabolizer?
For the <i>Texas Medicaid Preferred Drug List</i> , please refer to the Texas Medicaid Vendor Drug Program website at <a href="https://www.txvendordrug.com/formulary/formulary-search">https://www.txvendordrug.com/formulary/formulary-search</a>		

## 9. Physician signature

\_\_\_\_\_  
Prescriber or authorized signature

\_\_\_\_\_  
Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.*

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