Dupilumab (Dupixent)

Atopic Dermatitis

Coverage Criteria:

1. Prescribed by or in consultation with a dermatologist, allergist, or immunologist; and,
2. Diagnosed with moderate to severe atopic dermatitis with medical chart documentation of at least 10% body surface area (BSA), or involvement with the face, neck, hands, feet, or genitals AND for both of these indications have at least **two** of the following:
    a. Intractable pruritus (itching); or,
    b. Cracking and oozing/bleeding of affected skin; or,
    c. Impaired activities of daily living, and,
3. Failure or intolerance to one prescription-strength topical corticosteroid; and,
4. Dupixent will not be used in combination with another biologic medication for the treatment of atopic dermatitis; and,
5. Prescribed within the FDA approved dosing regimen.

Renewal Criteria:

1. Patient has been seen by a specialist (dermatologist, allergist, or immunologist) in the past 12 months; and,
2. Patient has documented improvement of symptoms, such as reduction pruritus or in area of skin affected; and,
3. Prescribed within the FDA approved dosing regimen.

Coverage Duration:
Initial authorizations will be for 6 months.
Reauthorizations for 12 months.

Other Criteria:
Dupixent 200 mg: 2 doses per 28 days
Dupixent 300 mg: up to 2 doses per 28 days
Exceptions will be made for initial loading doses.

Eosinophilic Asthma or Oral Corticosteroid Dependent Asthma

Coverage Criteria:

1. Prescribed by or in consultation with an asthma specialist, allergist, or pulmonologist; and,
2. Patient has inadequate asthma control defined as one of the following:
    a. At least 2 exacerbations requiring oral systemic corticosteroids in the past 12 months; or,

   b. At least one exacerbation treated in an emergency department or hospital in the past 12 months; and,
3. Patient has inadequate asthma control despite adherence to the following standard therapies:
   a. Regular use of inhaled corticosteroids (ICS), (such as Flovent); and,
   b. Regular use of long-acting beta-agonist (LABA), (such as Serevent); and,
4. Patient has one of the following diagnoses:
   a. Oral corticosteroid dependent asthma defined as one of the following:
      i. Receiving regular treatment with systemic glucocorticoid therapy during the previous 6 months (5-35 mg per day of prednisone or prednisolone or equivalent steroid); and,
      ii. Receiving high dose inhaled glucocorticoid therapy for at least 4 weeks (total daily dose ≥ 500 µg of fluticasone or equivalent); or,
   b. Eosinophilic asthma defined as the following:
      i. Pre-treatment eosinophil count ≥150 cells/mcL within the previous 12 months; and,
5. Patient is not currently using another biologic therapy for the treatment of asthma, such as Xolair, Fasenra, Cinqair, or Nucala; and,
6. Prescribed within the FDA approved dosing regimen.

Renewal Criteria:

1. Patient has been seen by provider in the past 12 months; and,
2. Patient has been adherent to therapy; and,
3. Patient has not experienced unacceptable toxicity from the drug; and,
4. Patient has a clinically meaningful response to the medication as defined:
   a. Decreased frequency of exacerbations defined as:
      i. Improvement of asthma control, demonstrated by decreased use of oral or systemic corticosteroids; or,
      ii. Less frequent hospitalizations; or,
      iii. Reduced frequency of emergency department visits; or,
   b. Improvement in lung function measured in FEV1; and,
5. Patient is not currently using another biologic therapy, for the treatment of asthma such as Cinqair, Nucala, Fasenra, or Xolair; and,
6. Prescribed within the FDA approved dosing regimen.

Coverage Duration:

Initial authorizations will be for 6 months.
Reauthorizations for 12 months.

Other Criteria:

Dupixent 100 mg: 2 doses per 28 days
Dupixent 200 mg: 2 doses per 28 days
Dupixent 300 mg: up to 2 doses per 28 days
Exceptions will be made for initial loading doses.

Chronic Rhinosinusitis with Nasal Polyposis

Coverage Criteria:

1. Patient is diagnosed with bilateral nasal polyposis and chronic symptoms of sinusitis; and,
2. Prescribed by or in consultation with an allergist, otolaryngologist, or pulmonologist; and,
3. Patient has tried and failed either:
    a. Intranasal corticosteroids for at least 3 months; or,
    b. Nasal polyps surgery, defined as recurrence of nasal polyps within 12 months of surgery; and,
4. Patient has moderate to severe symptoms defined as one of the following lasting greater than 12 weeks:
    a. Anterior or posterior rhinorrhea; or,
    b. Nasal congestion; or,
    c. Reduction or loss of smell; or,
    d. Nasal obstruction; and,
5. Patient will use a daily intranasal corticosteroid concomitantly with Dupixent; and,
6. Patient is not currently prescribed another biologic therapy for the treatment of nasal polyposis; and,
7. Prescribed within the FDA approved regimen.

Reauthorizations Criteria:

1. Patient has been seen by the prescriber in the past 12 months; and,
2. Provider attests patient has achieved clinical benefit from use of Dupixent for symptoms of chronic rhinosinusitis with nasal polyposis.

Coverage Duration:
Initial authorizations will be for 6 months.
Reauthorizations for 12 months.

Other Criteria:
Dupixent 300 mg: 2 doses per 28 days
Exceptions will be made for initial loading doses.

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Eosinophilic Esophagitis (EoE)

Coverage Criteria:

1. Prescribed by or in consultation with an allergist, pulmonologist, immunologist, or gastroenterologist; and,
2. Diagnosed with eosinophilic esophagitis (EoE) with medical chart documentation of endoscopic esophageal biopsy showing presence of eosinophilic count ≥15 eosinophils per high-power microscopy field (eos/hpf); and,
3. Patient has ongoing symptoms of EoE (e.g., dysphagia episodes, reflux-like symptoms, food impaction); and,
4. Patient has tried and failed both of the following for at least 8 weeks:
    a. High-dose proton pump inhibitors; and,
    b. Swallowed topical corticosteroids (e.g., budesonide); and,
5. Dupixent will not be used in combination with another biologic medication for the treatment of EoE; and,
6. Prescribed within the FDA approved dosing regimen.

Reauthorizations Criteria:

1. Patient has been seen by the prescriber in the past 12 months; and,
2. Provider attests patient has achieved clinical benefit from use of Dupixent for symptoms of eosinophilic esophagitis.

Coverage Duration:
Initial authorizations will be for 6 months.
Reauthorizations for 12 months.

Other Criteria:
Dupixent 300 mg: 4 doses per 28 days

Prurigo Nodularis (PN)

Coverage Criteria:

1. Prescribed by or in consultation with a dermatologist, allergist, or immunologist; and,
2. Diagnosed with prurigo nodularis (PN); and,
3. Patient has had a trial and failure of or contraindications to concurrent use of at least two of the regimens below for at least 12 weeks:
    a. Topical corticosteroid therapy or topical calcineurin inhibitors; or,
    b. Phototherapy for at least 20-30 treatments given 2-3 times weekly (Note: see the Home Phototherapy medical policy for coverage of home units); or,
    c. Methotrexate 7.5-20 mg weekly (Note: GI intolerance requires trial of SC/IM methotrexate at 7.5-20 mg weekly); or,
    d. Cyclosporine at a dose of at least 3-5 mg/kg/day until disease control achieved; or,
4. Dupixent will not be used in combination with another biologic medication for the treatment of PN; and,
5. Prescribed within the FDA approved dosing regimen.

Reauthorizations Criteria:

1. Patient has been seen by a specialist (dermatologist, allergist, or immunologist) in the past 12 months; and,
2. Patient has documented improvement of symptoms, such as a reduction of itching (pruritis) and inflammatory skin lesions (nodules); and,
3. Prescribed within the FDA approved dosing regimen.

Coverage Duration:
Initial authorizations will be for 6 months.
Reauthorizations for 12 months.

Other Criteria:
Dupixent 300 mg: 2 doses per 28 days
Exceptions will be made for initial loading doses.

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