# DUPILUMAB

**Included Products:** Dupixent (dupilumab)

*Created*: 03/14/2018 *Revised*: 11/14/2024 *Reviewed*: 11/14/2024 *Updated*: 12/1/2024

## Atopic Dermatitis

| Initial Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Is the member under the age of 21? | Continue to #2. | Continue to #4. |
| **2.** | Does the member meet all of the following:<br>a. Has chronic, moderate to severe atopic dermatitis (10% BSA, or hand, foot, face or mucous membrane involvement) with functional impairment; AND<br>b. Failure of a combination of steroid and nonsteroid topical medications. | Continue to #6. | Continue to #3. |
| **3.** | Has a medical director reviewed to confirm it is medically necessary and appropriate to treat Dupixent? | Continue to #6. | Do not approve based on medical necessity or appropriateness. |
| **4.** | Does the member meet all of the following:<br>a. Has chronic, moderate to severe atopic dermatitis (10% BSA, or hand, foot, face or mucous membrane involvement) with functional impairment; AND<br>b. Failure of TWO of the following:<br>i. A combination of steroid and nonsteroid topical medications; OR<br>ii. An oral DMARD such as methotrexate or cyclosporine; OR<br>iii. Phototherapy. | Continue to #5. | Do not approve. |
| **5.** | Is the request for every other week dosing? | Continue to #6. | Do not approve. |
| **6.** | Approve for 6 months. | | |
| **Renewal Criteria** | | **If yes** | **If no** |
| **1.** | Has the member experienced a 50% reduction in eczema and/or is there evidence of significant functional improvement? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months | | |

# Asthma

| Initial Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Is the request from a pulmonologist? | Continue to #2. | Do not approve. |
| **2.** | Does the member have severe asthma which is uncontrolled despite treatment with the following?<br>a. High dose inhaled corticosteroid with a long acting beta agonist (such as AirDuo, Advair, or Symbicort)<br>b. Leukotriene inhibitor (such as montelukast)<br>c. Long acting muscarinic antagonist (such as Spiriva) | Continue to #3. | Do not approve. |
| **3.** | Is the asthma defined as eosinophilic phenotype or oral corticosteroid dependent?<br>a. Eosinophilic phenotype, continue to #4.<br>b. Oral corticosteroid dependent, continue to #6.<br>c. If neither, do not approve. | | |
| **4.** | In the past year has the member had frequent asthma exacerbations resulting in repeated use of health care services, such as urgent care or ED visits or hospitalization? | Continue to #5. | Do not approve. |
| **5.** | Does the member have an eosinophil count of ≥150/µl within the past 6 months? | Continue to #7. | Do not approve. |
| **6.** | Does the member require oral steroids to maintain asthma control? | Continue to #7. | Do not approve. |
| **7.** | Approve for 6 months. | | |

| Renewal Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Has the member had a reduction in asthma exacerbations or a decrease in oral corticosteroid dose and demonstrated sustained clinical improvement from baseline? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Chronic Rhinosinusitis With Nasal Polyps

| Initial Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Is the request from an allergist or ENT? | Continue to #2. | Do not approve. |
| **2.** | Does the member have recurrent nasal polyps after multiple prior sinus surgeries within the past 2 years? | Continue to #3. | Do not approve. |
| **3.** | Has the member failed all of these treatments?<br>a. At least 2 prior intranasal corticosteroids<br>b. Sinuva | Continue to #4. | Do not approve. |
| **4.** | Is the member currently adherent to a nasal corticosteroid? | Continue to #5. | Do not approve. |

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| **5.** | Is the member at risk of another sinus surgery? | Continue to #6. | Do not approve. |
| **6.** | Is there a statement why sinus surgery is not medically appropriate? | Continue to #7. | Do not approve. |
| **7.** | Consult with medical director. | | |
| **Renewal Criteria** | | **If yes** | **If no** |
| **1.** | Has the member had a clinically significant improvement in symptoms and reduced risk of needing surgery? | Continue to #2. | Do not approve. |
| **2.** | Approve for 6 months. | | |

# Eosinophilic Esophagitis

| Initial Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Is the request from a gastroenterologist? | Continue to #2. | Do not approve. |
| **2.** | Is Dupixent indicated for the member's age and weight? | Continue to #3. | Do not approve. |
| **3.** | Does the member have eosinophilic esophagitis confirmed by imaging? | Continue to #4. | Do not approve. |
| **4.** | Does the member have two or more episodes of dysphagia every week? | Continue to #5. | Do not approve. |
| **5.** | Has the member failed at least 12 weeks of all of the following:<br>a. Swallowed inhaled corticosteroids<br>b. High dose PPI (such as omeprazole or pantoprazole) | Continue to #6. | Do not approve. |
| **6.** | Has the member failed dietary modifications? | Continue to #7. | Do not approve. |
| **7.** | Approve for 6 months. | | |
| **Renewal Criteria** | | **If yes** | **If no** |
| **1.** | Has the member had a clinically significant improvement in symptoms? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |

# Prurigo Nodularis

| Initial Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Is the member under age 21? | Continue to #2. | Continue to #4. |
| **2.** | Does the member meet all of the following:<br>a. Has chronic, moderate to severe prurigo nodularis (10% BSA, or hand, foot, face or mucous | Continue to #5. | Continue to #3. |

| | | | |
|---|---|---|---|
| | membrane involvement) with functional impairment; AND<br>b. Failure of a combination of steroid and nonsteroid topical medications. | | |
| **3.** | Has a medical director reviewed to confirm it is medically necessary and appropriate to treat Dupixent? | Continue to #5. | Do not approve based on medical necessity or appropriateness. |
| **4.** | Does the member meet all of the following:<br>a. Has chronic, moderate to severe prurigo nodularis (10% BSA, or hand, foot, face or mucous membrane involvement) with functional impairment; AND<br>b. Failure of TWO of the following:<br>i. A combination of steroid and nonsteroid topical medications; OR<br>ii. An oral DMARD such as methotrexate or cyclosporine; OR<br>iii. Phototherapy. | Continue to #5. | Do not approve. |
| **5.** | Approve for 6 months. | | |

| Renewal Criteria | | If yes | If no |
|---|---|---|---|
| **1.** | Has the member had a significant response in therapy, such as reduction in the number of nodules, significant decrease in pruritus, and/or functional improvement? | Continue to #2. | Do not approve. |
| **2.** | Approve for 12 months. | | |