STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Services
Prior Authorization Criteria
DUPIXENT® (dupilumab)

Effective 1/1/2022

Prior Authorization Request Form

DUPIXENT *is an interleukin-4 receptor alpha antagonist indicated:*

I. For the treatment of patients aged 6 years and older with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. DUPIXENT can be used with or without topical corticosteroids.
II. As an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.
III. As an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

I. For the Indication of Atopic Dermatitis, prior authorization requests may be approved if the following criteria are met:

1. Prescribed by or in consultation with an allergist, immunologist or dermatologist; **AND**

2. Documented diagnosis of moderate to severe Atopic Dermatitis (AD). Documentation must include the affected BSA, areas of involvement and severity of symptoms; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. Affected body surface area is greater than or equal to 10%; **AND**

5. Patient has failed to find relief of symptoms after a minimum of 30-day trials of two agents from the following list in the last 12 months:

    a. Medium to High potency topical corticosteroid*
    b. Elidel
    c. Eucrisa
    d. Tacrolimus

*Trial of medium to high potency topical steroid is required unless the affected area involves sensitive areas such as the face, skin folds or genitals. However, a trial of two other agents among the list above, are still required prior to Dupixent approval.

Initial approval of Dupixent for atopic dermatitis will be for 90 days. Additional therapy shall be approvable with documentation of satisfactory patient response (including current affected BSA and severity of symptoms).

II. For the indication of Asthma, prior authorization requests may be approved if the following criteria are met:

1. Prescribed by or in consultation with an allergist, immunologist or pulmonologist; **AND**

2. The patient must be within the age range as recommended by the FDA label and indication; **AND**

3. Patient must have documented adherence to a therapeutic regimen consisting of a LABA + high dose ICS therapy in the last 90 days; **AND**

4. Documentation must be supplied indicating one of the following:

    a. A positive sputum test for eosinophilic phenotype asthma with sputum eosinophil level ≥ 3% **OR**
    b. Asthma with eosinophilic phenotype with blood eosinophil count greater than or equal to 150 cells/mcL within the past 6 weeks or blood eosinophil count greater than or equal to 300 cells/mcL in the past 12 months; **OR**
    c. Claims data that reflect a continual reliance on oral corticosteroid therapy in the last 90 days.

Initial approval of Dupixent for asthma will be for 90 days. Additional therapy shall be approvable with documentation of satisfactory patient response and compliance on inhaled therapy.

III. For the indication of Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), prior authorization requests may be approved if the following criteria are met:

1. Must be prescribed by or in consultation with, an ENT, allergist, or other suitable specialist; **AND**

2. Member must have a diagnosis of CRSwNP which has been inadequately controlled after at least 3-months of therapy with any intranasal steroid; **AND**

3. The patient must be within the approved age range according to the FDA label and indication; **AND**

4. Dupixent is only approvable as add-on therapy for CRSwNP.

Continuation of coverage requires documentation of reduction/elimination of nasal polyps AND patient adherence to therapy (including the original agent Dupixent was supplementing).

References:

1.) LexiComp monograph for dupliumab (accessed 09/09/2019), 3/21, 11/21
2.) Dupixent package insert revision 06/2019, 3/21, 11/21
3.) GINA: Difficult-to-treat and Severe Asthma in adolescents and adults patients. V2.0 April 2019 (www.ginasthma.org)
4.) UpToDate literature review on the treatment of severe asthma in adolescents and adults (11/07/2018)
5.) UpToDate literature review on the treatment of atopic dermatitis (11/2018)
6.) https://www.aad.org/practicecenter/quality/clinical-guidelines/atopic-dermatitis/diagnosis-and-assessment/disease-severity-recommendations
7.) https://www.ecu.edu/cs-dhs/fammed/upload/Atopic-Dermatitis-Guidelines.pdf
8.) https://journal.chestnet.org/article/S0012-3692(11)60278-X/pdf (Point: Is Measuring Sputum Eosinophils Useful in the Management of Sever Asthma? Yes) Chest/139/6/June,2011 p 1271-1273.
9.) https://journal.chestnet.org/article/S0012-3692(11)60279-1/pdf (Counterpoint: Is Measuring Sputum Eosinophils Useful in the Management of Severe Asthma? No, Not for the Vast Majority of Patients) Chest/139/6/June,2011 p 1273-1275.