

Clinical Policy: Dupilumab (Dupixent)

Reference Number: HIM.PA.SP69

Effective Date: 06.01.24 Last Review Date: 02.25 Line of Business: HIM

Coding Implications
Revision Log

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

Description

Dupilumab (Dupixent®) is an interleukin-4 and interleukin-13 receptor alpha antagonist.

FDA Approved Indication(s)

Dupixent is indicated:

- For the treatment of adult and pediatric patients aged 6 months 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.
- As an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma.
- As an add-on maintenance treatment in adult and pediatric patients aged 12 and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).
- For the treatment of adult and pediatric patients aged 1 year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE).
- For the treatment of adult patients with prurigo nodularis (PN).
- As an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype.
- For the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment.
- For the treatment of adult patients with bullous pemphigoid (BP).

Limitation(s) of use: Not for the relief of acute bronchospasm or status asthmaticus. Not indicated for other forms of urticaria.

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 Dupixent is **medically necessary** when the following criteria are met:



I. Initial Approval Criteria

A. Atopic Dermatitis (must meet all):

- 1. Diagnosis of atopic dermatitis 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 \geq 6 months;
- 4. Failure of both of the following (a and b), unless contraindicated or clinically significant adverse effects are experienced:
 - a. One formulary medium to very high potency topical corticosteroid 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. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry[™], Cinqair[®], Fasenra[®], Nucala[®], Tezspire[™], Xolair[®]) or a Janus kinase (JAK) inhibitor (e.g., Olumiant[®], Rinvoq[®], Cibinqo[®], Opzelura[™]);
- 6. Dose does not exceed one of the following (a, b, or c):
 - a. Age 6 months to 5 years and weight 5 to < 15 kg: 200 mg every 4 weeks;
 - b. Age 6 months to 5 years and weight 15 to < 30 kg: 300 mg every 4 weeks;
 - c. Age \geq 6 years and the following:
 - i. Initial (one-time) dose:
 - 1) Age \geq 18 years, weight \geq 60 kg, or age 6-17 years and weight 15 to < 30 kg: 600 mg;
 - 2) Age 6-17 years and weight 30 to < 60 kg: 400 mg;
 - ii. Maintenance dose:
 - 1) Age \geq 18 years or weight \geq 60 kg: 300 mg every other week;
 - 2) Age 6-17 years and weight 30 to < 60 kg: 200 mg every other week;
 - 3) Age 6-17 years and weight 15 to < 30 kg: 300 mg every 4 weeks.

Approval duration: 6 months

B. Asthma (must meet all):

- 1. Diagnosis of asthma and one of the following (a or b):
 - a. Absolute blood eosinophil count ≥ 150 cells/mcL within the past 3 months;
 - b. Currently receiving maintenance treatment with systemic glucocorticoids and has received treatment for at least 4 weeks;
- 2. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist;
- 3. Age \geq 6 years;
- 4. Member has experienced ≥ 1 exacerbation within the last 12 months, requiring one of the following (a or b), despite adherent use of controller therapy (i.e., medium- to high-dose inhaled corticosteroid [ICS] plus a long-acting beta₂ agonist [LABA] or ICS plus one additional asthma controller medication):
 - a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
 - b. Urgent care/emergency room (ER) visit or hospital admission;



- 5. Dupixent is prescribed concurrently with an ICS plus either a LABA or one additional asthma controller medication;
- 6. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 7. Dose does not exceed the following:
 - a. Initial (one-time) dose for age \geq 12 years: 600 mg;
 - b. Maintenance dose:
 - i. Age \geq 12 years: 300 mg every other week;
 - ii. Age 6-11 years and weight ≥ 30 kg: 200 mg every other week;
 - iii. Age 6-11 years and weight 15 to < 30 kg: 300 mg every 4 weeks.

Approval duration: 6 months

C. Chronic Rhinosinusitis with Nasal Polyposis (must meet all):

- 1. Diagnosis of CRSwNP with documentation of all of the following (a, b, and c):
 - a. Presence of nasal polyps;
 - b. Disease is bilateral;
 - c. Member has experienced signs and symptoms (e.g., nasal congestion/blockage/ obstruction, loss of smell, rhinorrhea) for ≥ 12 weeks;
- 2. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist;
- 3. Age \geq 12 years;
- 4. Member has required the use of systemic corticosteroids for symptom control within the last 2 years, unless contraindicated or clinically significant adverse effects are experienced (see Appendix B for examples);
- 5. Failure of maintenance therapy with one intranasal corticosteroid used for ≥ 4 weeks, unless contraindicated or clinically significant adverse effects are experienced (see Appendix B for examples);
- 6. Dupixent is prescribed concurrently with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced (see Appendix B for examples);
- 7. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 8. Dose does not exceed 300 mg every other week.

Approval duration: 6 months

D. Eosinophilic Esophagitis (must meet all):

- 1. Diagnosis of EoE confirmed by ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) on endoscopic biopsy;
- 2. Prescribed by or in consultation with an allergist, immunologist, or gastroenterologist;
- 3. Age ≥ 1 year;
- 4. Weight \geq 15 kg;
- 5. Member does not have hypereosinophilic syndrome or eosinophilic granulomatosis with polyangiitis (formerly Churg-Strauss syndrome);



- 6. Failure of one of the following (a or b), unless clinically significant adverse effects are experienced or both are contraindicated:
 - a. Proton pump inhibitor (see Appendix B for examples);
 - b. Corticosteroid (see Appendix B for examples);
- 7. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 8. Dose does not exceed the following:
 - a. Weight 15 to < 30 kg: 200 mg every other week;
 - b. Weight 30 to < 40 kg: 300 mg every other week;
 - c. Weight \geq 40 kg: 300 mg every week.

Approval duration: 6 months

E. Prurigo Nodularis (must meet all):

- 1. Diagnosis of PN with documentation of both of the following (a and b, *see Appendix F*):
 - a. Numeric rating scale ≥ 7 on a scale of 0 ("no itch") to 10 ("worst imaginable itch") (e.g., Peak Pruritus Numeric Rating Scale, Worst Itch-Numeric Rating Scale);
 - b. ≥ 20 nodular lesions total on both legs, and/or both arms and/or trunk;
- 2. Prescribed by or in consultation with a dermatologist;
- 3. Age \geq 18 years;
- 4. Failure of a \geq 2-week course of a medium to very high potency topical corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
- 5. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 6. Dose does not exceed the following:
 - a. Initial (one-time) dose: 600 mg;
 - b. Maintenance dose: 300 mg every other week.

Approval duration: 6 months

F. Chronic Obstructive Pulmonary Disease (must meet all):

- 1. Diagnosis of COPD as evidenced by one of the following (a or b):
 - a. Postbronchodilator ratio of the forced expiratory volume in 1 second (FEV_1) /forced vital capacity (FVC) < 0.7;
 - b. Postbronchodilator FEV₁ \geq 20 % and \leq 80% of predicted normal;
- 2. Age \geq 18 years;
- 3. Documentation of eosinophilic phenotype with blood eosinophil count of ≥ 300 cells/ μ L;
- 4. Member has history of ≥ 2 moderate or ≥ 1 severe exacerbations within the past 12 months:
- 5. Member meets one of the following (a or b, *see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated:



- a. Failure of triple inhaled therapy consisting of a combination of LABA + long-acting antimuscarinic antagonist (LAMA) + ICS, at up to maximally indicated doses for ≥ 3 months;
- b. If member is contraindicated to ICS, failure of dual inhaled therapy consisting of a combination of LABA + LAMA, at up to maximally indicated doses for ≥ 3 months:
- 6. Provider attestation that member is concomitantly receiving triple therapy maintenance (e.g., LABA + LAMA + ICS) or double therapy maintenance (e.g., LABA + LAMA) if ICS is contraindicated;
- 7. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 8. Dose does not exceed 300 mg every other week.

Approval duration: 6 months

G. Chronic Spontaneous Urticaria (must meet all):

- 1. Diagnosis of CSU;
- 2. Prescribed by or in consultation with a dermatologist, immunologist, or allergist;
- 3. Age \geq 12 years;
- 4. Failure of both of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a and b):
 - a. Two antihistamines (including one second generation antihistamine e.g., cetirizine, levocetirizine, fexofenadine, loratadine, desloratadine) at maximum indicated doses, each used for ≥ 2 weeks;
 - b. A LTRA in combination with an antihistamine at maximum indicated doses for ≥ 2 weeks;
- 5. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 6. Dose does not exceed one of the following (a or b):
 - a. Age \geq 18 years, both of the following (i and ii):
 - i. Initial (one-time) dose: 600 mg;
 - ii. Maintenance dose: 300 mg every other week;
 - b. Age 12-17 years, both of the following (i and ii):
 - i. Initial (one-time) dose (1 or 2):
 - 1) Weight \geq 60 kg: 600 mg;
 - 2) Weight 30 to < 60 kg: 400 mg;
 - ii. Maintenance dose (1 or 2):
 - 1) Weight \geq 60 kg: 300 mg every other week;
 - 2) Weight 30 to \leq 60 kg: 200 mg every other week.

Approval duration: 6 months

H. Bullous Pemphigoid (must meet all):

1. Diagnosis of BP;



- 2. Diagnosis is confirmed histologically, serologically (e.g., anti-BP180 IgG autoantibodies and/or anti-BP230 IgG autoantibodies by ELISA), or by immunofluorescence;
- 3. Prescribed by or in consultation with a dermatologist;
- 4. Age \geq 18 years;
- 5. Inadequate response to at least one corticosteroid (e.g., prednisone) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
- 6. Failure of at least one non-steroidal immunosuppressive agent (e.g., azathioprine, mycophenolate mofetil, methotrexate) (see Appendix B) at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
- 7. Prescribed in combination with a tapering course of oral corticosteroid;
- 8. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 9. Dose does not exceed both of the following (a and b):
 - a. Initial (one-time) dose: 600 mg;
 - b. Maintenance dose: 300 mg every other week.

Approval duration: 6 months

I. Immunotherapy-related Pruritus (off-label) (must meet all):

- 1. Diagnosis of immune checkpoint inhibitor-related toxicity that is one of the following (a or b; *see Appendix E*):
 - a. Pruritus that is severe (G3);
 - b. Bullous dermatitis that is moderate (G2), severe (G3), or life-threatening (G4);
- 2. Prescribed by or in consultation with an oncologist;
- 3. For severe (G3) pruritus, member has not responded to a gabapentinoid (e.g., gabapentin, pregabalin) after 1 month of therapy;
- 4. For moderate (G2) bullous dermatitis, member has not responded to ≥ 3 days of prednisone or methylprednisolone;
- 5. Dupixent is not prescribed concurrently with Cinqair, Fasenra, Nucala, Xolair, or Tezspire;
- 6. Dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (prescriber must submit supporting evidence).*

*Prescribed regimen must be FDA-approved or recommended by NCCN

Approval duration: 6 months

J. 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: HIM.PA.33 for health insurance marketplace; 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: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

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. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed:
 - a. Age \geq 18 years or weight \geq 60 kg: 300 mg every other week;
 - b. Age 6-17 years and weight 30 to < 60 kg: 200 mg every other week;
 - c. Age 6-17 years and weight 15 to < 30 kg: 300 mg every 4 weeks;
 - d. Age 6 months to 5 years and weight 5 to < 15 kg: 200 mg every 4 weeks;
 - e. Age 6 months to 5 years and weight 15 to < 30 kg: 300 mg every 4 weeks.

Approval duration: 12 months

B. Asthma (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. Demonstrated adherence to asthma controller therapy (an ICS plus either a LABA or additional asthma controller medication) as evidenced by proportion of days covered (PDC) of 0.8 in the last 6 months (i.e., member has received asthma controller therapy for at least 5 of the last 6 months);
- 3. Member is responding positively to therapy (examples may include but are not limited to: reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, reduction in the use of rescue therapy);



- 4. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 5. If request is for a dose increase, new dose does not exceed:
 - a. Age \geq 12 years: 300 mg every other week;
 - b. Age 6-11 years and weight \geq 30 kg: 200 mg every other week;
 - c. Age 6-11 years and weight 15 to < 30 kg: 300 mg every 4 weeks.

Approval duration: 12 months

C. Chronic Rhinosinusitis with Nasal Polyposis (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. Demonstrated adherence to an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
- 3. Member is responding positively to therapy (examples may include but are not limited to: reduced nasal polyp size, reduced need for systemic corticosteroids, improved sense of smell, improved quality of life);
- 4. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 5. If request is for a dose increase, new dose does not exceed 300 mg every other week.

Approval duration: 12 months

D. Eosinophilic Esophagitis (must meet all):

- 1. Currently 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 (examples may include but are not limited to: reduced eos/hpf count, improvement in dysphagia symptoms);
- 3. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed the following:
 - a. Weight 15 to < 30 kg: 200 mg every other week;
 - b. Weight 30 to < 40 kg: 300 mg every other week;
 - c. Weight > 40 kg: 300 mg every week.

Approval duration: 12 months



E. Prurigo Nodularis (must meet all):

- 1. Currently 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 (examples may include but are not limited to: improvement in itching or skin pain, reduction in number of nodules);
- 3. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed 300 mg every other week.

Approval duration: 12 months

F. Chronic Obstructive Pulmonary Disease (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;
- 3. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed 300 mg given every other week

Approval duration: 12 months

G. Chronic Spontaneous Urticaria (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;
- 3. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed the following:
 - a. Age \geq 18 years or weight \geq 60 kg: 300 mg every other week;
 - b. Age 12-17 years and weight 30 to < 60 kg: 200 mg every other week.

Approval duration: 12 months



H. Bullous Pemphigoid (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;
- 3. Dupixent is not prescribed concurrently with another biologic immunomodulator (e.g., Adbry, Cinqair, Fasenra, Nucala, Tezspire, Xolair) or a JAK inhibitor (e.g., Olumiant, Rinvoq, Cibinqo, Opzelura);
- 4. If request is for a dose increase, new dose does not exceed 300 mg given every other week.

Approval duration: 12 months

I. Immunotherapy-related Pruritus (off-label) (must meet all):

- 1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Dupixent for a covered indication and has received this medication for at least 30 days;
- 2. Member is responding positively to therapy;
- 3. If request is for a dose increase, new dose is within FDA maximum limit for any FDA-approved indication or is supported by practice guidelines or peer-reviewed literature for the relevant off-label use (*prescriber must submit supporting evidence*).*

 *Prescribed regimen must be FDA-approved or recommended by NCCN.

Approval duration: 6 months

J. 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: HIM.PA.33 for health insurance marketplace; 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: HIM.PA.103 for health insurance marketplace; 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: HIM.PA.154 for health insurance marketplace.

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 HIM.PA.154 for health insurance marketplace or evidence of coverage documents;
- **B.** Acute bronchospasm or status asthmaticus.



IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

ADL: activity of daily living

BP: bullous pemphigoid

IGS: inhaled corticosteroid

IgG: immunoglobulin G

CRSwNP: chronic rhinosinusitis with nasal polyposis

LABA: long-acting beta2 agonist

CSU: chronic spontaneous urticaria LTRA: leukotriene modifier EoE: eosinophilic esophagitis PDC: proportion of days covered

eos/hpf: eosinophils per high-power field PN: prurigo nodularis FDA: Food and Drug Administration WI-NRS: Worst Itch-Numeric Rating Scale GINA: Global Initiative for Asthma

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		
ATOPIC DERMATITIS, PN, BP				
	Very High Potency Topical Corticosteroids			
augmented betamethasone 0.05%	Apply topically to the affected	Varies		
(Diprolene® AF) cream, ointment,	area(s) BID			
gel, lotion				
clobetasol propionate 0.05%				
(Temovate®) cream, ointment,				
gel, solution				
diflorasone diacetate 0.05%				
(Maxiflor®, Psorcon E®) cream,				
ointment				
fluocinonide 0.1% cream				
flurandrenolide 4 mcg/cm ² tape				
halobetasol propionate 0.05%				
(Ultravate®) cream, ointment				
High Potency Topical Corticoster				
amcinonide 0.1% ointment, lotion	Apply topically to the affected	Varies		
augmented betamethasone 0.05%	area(s) BID			
(Diprolene® AF) cream, ointment,				
gel, lotion				
betamethasone valerate 0.1%,				
0.12% (Luxiq®) ointment, foam				
clobetasol propionate 0.025%				
(Impoyz [®]) cream				
diflorasone 0.05% (Florone®,				
Florone E [®] , Maxiflor [®] , Psorcon				
E [®]) cream				



Drug Name	Dosing Regimen	Dose Limit/
fluoring mid-cost mid-0.050/		Maximum Dose
fluocinonide acetonide 0.05%		
(Lidex®, Lidex E®) cream,		
ointment, gel, solution		
fluticasone propionate 0.005%		
cream, ointment		
halcinonide 0.1% cream,		
ointment, solution (Halog®)		
halobetasol propionate 0.01% lotion (Bryhali®)		
mometasone furoate 0.1%		
ointment		
triamcinolone acetonide 0.5%		
(Aristocort [®] , Kenalog [®]) cream,		
ointment		
Medium Potency Topical Cortico	steroids	
clocortolone pivalate 0.1% cream	Apply topically to the affected	Varies
desoximetasone 0.05%, 0.25%	area(s) BID	
(Topicort ®) cream, ointment, gel,		
spray		
fluocinolone acetonide 0.025%		
(Synalar®) cream, ointment		
flurandrenolide 0.05% lotion,		
ointment (Cordran®)		
hydrocortisone valerate 0.2%		
cream		
mometasone 0.1% (Elocon®)		
cream, ointment, lotion		
triamcinolone acetonide 0.025%,		
0.1% (Aristocort [®] , Kenalog [®])		
cream, ointment		
Other Classes of Agents		
Protopic® (tacrolimus), Elidel®	Children ≥ 2 years and adults:	Varies
(pimecrolimus)	Apply a thin layer topically to	Varies
(piniceroninas)	affected skin BID. Treatment	
	should be discontinued if	
	resolution of disease occurs.	
Eucrisa® (crisaborole)	Atopic dermatitis:	Varies
(21222 2121)	Apply to the affected areas BID	
cyclosporine	3-6 mg/kg/day PO BID	300 mg/day
azathioprine	1-3 mg/kg/day PO QD	Weight-based
methotrexate	7.5-25 mg/wk PO once weekly	25 mg/week
mycophenolate mofetil	1-1.5 g PO BID	3 g/day
ASTHMA		5 5 au j



Drug Name	Dosing Regimen	Dose Limit/
0		Maximum Dose
ICS (medium – high dose)		
Qvar® (beclomethasone)	> 100 mcg/day	4 actuations BID
,	40 mcg, 80 mcg per actuation	
	1-4 actuations BID	
budesonide (Pulmicort®)	> 200 mcg/day	2 actuations BID
	90 mcg, 180 mcg per actuation	
	2-4 actuations BID	
Alvesco® (ciclesonide)	> 80 mcg/day	2 actuations BID
	80 mcg, 160 mcg per actuation	
	1-2 actuations BID	
fluticasone propionate (Flovent®)	> 100 mcg/day	2 actuations BID
	44-250 mcg per actuation	
_	2-4 actuations BID	
Arnuity Ellipta® (fluticasone	$\geq 50 \text{ mcg/day}$	1 actuation QD
furoate)	100 mcg, 200 mcg per actuation	
	1 actuation QD	011111 PVD
Asmanex® (mometasone)	> 100 mcg/day	2 inhalations BID
	HFA: 100 mcg, 200 mcg per	
	actuation	
	Twisthaler: 110 mcg, 220 mcg	
	per actuation	
LABA	1-2 actuations QD to BID	
Serevent® (salmeterol)	50 mcg per dose	1 inhalation BID
Selevent (samieteror)	1 inhalation BID	
Combination Products (ICS + La		
Dulera® (mometasone/	100/5 mcg, 200/5 mcg per	4 actuations per day
formoterol)	actuation	, accumined per amy
Tormotoror)	2 actuations BID	
Breo Ellipta®	100/25 mcg, 200/25 mcg per	1 actuation QD
(fluticasone/vilanterol)	actuation	
(1 actuation QD	
fluticasone/ salmeterol (Advair®)	Diskus: 100/50 mcg, 250/50	1 actuation BID
,	mcg, 500/50 mcg per actuation	
	HFA: 45/21 mcg, 115/21 mcg,	
	230/21 mcg per actuation	
	1 actuation BID	
fluticasone/salmeterol (Airduo	55/13 mcg, 113/14 mcg, 232/14	1 actuation BID
RespiClick®)	mcg per actuation	
	1 actuation BID	
budesonide/	80 mcg/4.5 mcg, 160 mcg/4.5	2 actuations BID
formoterol (Symbicort®)	mcg per actuation	
	2 actuations BID	
LTRA		



Drug Name	Dosing Regimen	Dose Limit/
		Maximum Dose
montelukast (Singulair®)	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate®)	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo® CR)	1,200 mg PO BID	2,400 mg per day
Zyflo® (zileuton)	600 mg PO QID	2,400 mg per day
Oral Corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	40 to 80 mg PO in 1 to 2 divided doses	Varies
CRSwNP		
Intranasal Corticosteroids		
beclomethasone (Beconase AQ [®] , Qnasl [®])	1-2 sprays IN BID	2 sprays/nostril BID
budesonide (Rhinocort® Aqua, Rhinocort®)	128 mcg IN QD or 200 mcg IN BID	1-2 inhalations/ nostril/day
flunisolide	2 sprays IN BID	2 sprays/nostril TID
fluticasone propionate (Flonase®)	1-2 sprays IN BID	2 sprays/nostril BID
mometasone (Nasonex®)	2 sprays IN BID	2 sprays/nostril BID
Omnaris®, Zetonna® (ciclesonide)	Omnaris: 2 sprays IN QD Zetonna: 1 spray IN QD	Omnaris: 2 sprays/ nostril/day Zetonna: 2 sprays/ nostril/day
triamcinolone (Nasacort®)	2 sprays IN QD	2 sprays/ nostril/day
Xhance [™] (fluticasone propionate)	1 to 2 sprays (93 mcg/spray) to nostril IN BID	744 mcg/day
Oral Corticosteroids		
dexamethasone (Decadron®)	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol®)	4 to 48 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred®, Orapred ODT®)	5 to 60 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone®)	5 to 60 mg PO in 1 to 2 divided doses	Varies
EoE		
Corticosteroids: examples – • <u>Topical</u> :	Varies	Varies



Drug Name	Dosing Regimen	Dose Limit/
		Maximum Dose
 Budesonide administered 		
as an oral viscous slurry of		
budesonide inhalation		
suspension [Pulmicort		
Respules [®]] with sucralose		
or similar carrier vehicle		
 Fluticasone propionate 		
administered using a		
metered dose inhaler		
• <u>Oral</u> :		
 Prednisone 		
Proton pump inhibitors (e.g.,	Varies	Varies
omeprazole, esomeprazole,		
lansoprazole, rabeprazole,		
pantoprazole)		
COPD		
IC	CS/LABA Combinations	
fluticasone/salmeterol	Refer to prescribing information	Refer to prescribing
(Advair Diskus®)		information
Breo Ellipta®		
(fluticasone/vilanterol)		
budesonide/formoterol		
(Symbicort®)		
Dulera ^{®*}	Doses of 10 mcg	The optimal dose
(mometasone/formoterol)	formoterol/400 mcg	has not been
	mometasone and 10 mcg	established
	formoterol/ 200 mcg	
	mometasone, each inhaled BID,	
	have been studied	
	BA/LAMA Combinations	
Bevespi Aerosphere®	Refer to prescribing information	Refer to prescribing
(formoterol/glycopyrrolate)		information
Utibron Neohaler®		
(indacaterol/glycopyrrolate)		
Anoro Ellipta®		
(vilanterol/umeclidinium)		
Stiolto Respimat®		
(olodaterol/tiotropium)		
	LAMAs	
Tudorza Pressair®	Refer to prescribing information	Refer to prescribing
(aclidinium bromide)		information
Seebri Neohlaer®		
(glycopyrrolate)		



Drug Name	Dosing Regimen	Dose Limit/
		Maximum Dose
Spiriva Respimat®/		
HandiHaler® (tiotropium)		
Incruse Ellipta® (umeclidinium)]	
	LABAs	
Brovana® (arformoterol)	Refer to prescribing information	Refer to prescribing
Arcapta Neohaler® (indacterol)		information
Striverdi Respimat® (olodaterol)		
Serevent Diskus® (salmeterol)		
	LABA/LAMA Combinations	
Trelegy [™] Ellipta [®]	1 inhalation by mouth QD	1 inhalation/day
(fluticasone/umeclidinium/		
vilanterol)		
IMMUNOTHERAPY-RELATE	D MODERATE (G2) BULLOUS	DERMATITIS
corticosteroids: examples –	1-2 mg/kg/day	Varies
prednisone, IV	Treat until symptoms improve	
methylprednisolone	to Grade ≤ 1 , then taper over 4—	
	6 weeks.	
CSU		
hydroxyzine (Vistaril®)	Adult: 25 mg PO TID to QID	Adult: Will vary
	Age \geq 6 years: 50 mg-100	according to
	mg/day in divided doses	condition
		Age \geq 6 years: 50
		mg-100 mg/day in
1 1' 1 1 1 ' /P' 1 1/P'		divided doses
diphenhydramine (Benadryl®)	Adult: 25 mg to 50 mg PO TID	Adult: Will vary
diphenhydramine (Benadryl®)	to QID	Adult: Will vary according to
diphenhydramine (Benadryl®)	to QID Pediatric: 12.5 mg to 25 mg PO	Adult: Will vary according to condition
diphenhydramine (Benadryl®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or	Adult: Will vary according to condition Children: 300
	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day	Adult: Will vary according to condition Children: 300 mg/day
chlorpheniramine (Aller- Chlor®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24
	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours	Adult: Will vary according to condition Children: 300 mg/day
	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24
chlorpheniramine (Aller- Chlor®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day
chlorpheniramine (Aller- Chlor®) cetirizine (Zyrtec®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours 5 to 10 mg PO QD	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day 10 mg/day
chlorpheniramine (Aller- Chlor®) cetirizine (Zyrtec®) levocertirizine (Xyzal®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours 5 to 10 mg PO QD 2.5 mg to 5 mg PO QD	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day 10 mg/day 5 mg/day
chlorpheniramine (Aller- Chlor®) cetirizine (Zyrtec®) levocertirizine (Xyzal®) loratadine (Claritin®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours 5 to 10 mg PO QD 2.5 mg to 5 mg PO QD 10 mg PO QD	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day 10 mg/day 5 mg/day 10 mg/day
chlorpheniramine (Aller- Chlor®) cetirizine (Zyrtec®) levocertirizine (Xyzal®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours 5 to 10 mg PO QD 2.5 mg to 5 mg PO QD	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day 10 mg/day 5 mg/day 10 mg/day Will vary according
chlorpheniramine (Aller- Chlor®) cetirizine (Zyrtec®) levocertirizine (Xyzal®) loratadine (Claritin®)	to QID Pediatric: 12.5 mg to 25 mg PO TID to QID or 5 mg/kg/day or 150 mg/m²/day Immediate Release: 4 mg PO every 4 to 6 hours Extended Release: 12 mg PO every 12 hours 5 to 10 mg PO QD 2.5 mg to 5 mg PO QD 10 mg PO QD	Adult: Will vary according to condition Children: 300 mg/day Do not exceed 24 mg/day 10 mg/day 5 mg/day 10 mg/day

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.
*Off-label



Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to Dupixent or any of its excipients
- Boxed warning(s): none reported

Appendix D: General Information

• Atopic dermatitis

 The Phase III pivotal studies (SOLO 1 and SOLO 2) of Dupixent showed no significant difference in clinical outcomes between dosing of Dupixent every week and every other week for the treatment of atopic dermatitis.

• Asthma

- Ouring clinical trials (LIBERTY ASTHMA QUEST), among patients with a baseline blood eosinophil count of < 150 per cubic millimeter, the exacerbation rate was similar with dupilumab and with placebo: 0.47 (95% CI, 0.36 to 0.62) with lower-dose dupilumab and 0.51 (95% CI, 0.35 to 0.76) with matched placebo, and 0.74 (95% CI, 0.58 to 0.95) with higher-dose dupilumab and 0.64 (95% CI, 0.44 to 0.93) with matched placebo.</p>
- The Global Initiative for Asthma (GINA) guidelines for difficult-to-treat and severe asthma recommend Dupixent be considered as adjunct therapy for patients 6 years of age and older with exacerbations or poor symptom control despite taking at least high dose ICS/LABA and who have eosinophilic biomarkers or need maintenance oral corticosteroids.
- Patients could potentially meet asthma criteria for both Xolair and Dupixent, though
 there is insufficient data to support the combination use of multiple asthma biologics.
 The combination has not been studied. Approximately 30% of patients in the Nucala
 MENSA study also were candidates for therapy with Xolair.
- Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: https://www.fasenrahcp.com/eosinophilcalculator
- O PDC is a measure of adherence. PDC is calculated as the sum of days covered in a time frame divided by the number of days in the time frame. To achieve a PDC of 0.8, a member must have received their asthma controller therapy for 144 days out of the last 180 days, or approximately 5 months of the last 6 months.

• CSU:

- CSU is classified as spontaneous onset of wheals, angioedema, or both, for more than 6 weeks due to an unknown cause.
- Clinical studies have shown that dupilumab significantly improved the signs and symptoms of chronic idiopathic urticaria compared to placebo in patients who had remained symptomatic despite the use of approved dose of H₁- antihistamine. Dupilumab was also studied in patients who remained symptomatic despite H₁-antihistamine and anti-IgE treatments (CUPID Study B), but did not meet statistical significance for reduction in the primary endpoint Itch Severity Score over 7 days (ISS7) at Week 24.
- Dupilumab for CSU is not currently included in clinical guideline treatment algorithms.
 - The 2014 Joint Task Force on Practice Parameters representing various American allergy organizations include omalizumab in combination with H1-



antihistamines as a fourth line treatment option following a stepwise approach starting with a second generation antihistamine. This is followed by one or more of the following: a dose increase of the second generation antihistamine, or the addition of another second generation antihistamine, H2-antagonist, LTRA, or first generation antihistamine. Treatment with hydroxyzine or doxepin can be considered in patients whose symptoms remain poorly controlled.

- The EAACI/GA2LEN/EDF/AAAAI/WAO Guideline for the Management of Urticaria include omalizumab in combination with H₁-antihistamines as a third line treatment option in patients who have failed to respond to higher doses of H₁- antihistamines.
- The use of over-the-counter H₁ antihistamines may not be a benefit to the treatment of CSU. Credit will be given for their use, but will not be covered under plan.

Appendix E: Immunotherapy-related Pruritus

- Immunotherapy refers to immune checkpoint inhibitors. Immune checkpoint inhibitors comprise a class of agents that target immune cell checkpoints, such as programmed cell death-1 (PD-1; e.g., Opdivo®, Keytruda®) and PD-1 ligand (PD-L1; e.g., Tecentriq®, Bavencio®, Imfinzi®), as well as cytotoxic T-lymphocyte—associated antigen 4 (e.g., Yervoy®, Imjudo®).
- NCCN grading of pruritus
 - o G1: Mild or localized
 - G2: Moderate. Intense or widespread; intermittent; skin changes from scratching (e.g., edema, papulation, excoriations, lichenification, oozing/crusts); limiting instrumental activities of daily living (ADLs)
 - o G3: Severe. Intense or widespread; constant; limiting self-care ADLs or sleep
- NCCN grading of bullous dermatitis
 - o G1: asymptomatic; blisters covering < 10% BSA
 - o G2: Blisters covering 10%-30% BSA; painful blisters; limiting instrumental ADLs
 - o G3: Blisters covering > 30% BSA; limiting self-care ADLs
 - o G4: Blisters covering > 30% BSA; associated with fluid or electrolyte abnormalities; intensive care unit (ICU) care or burn unit indicated

Appendix F: Numerical Rating Scale

• The Peak Pruritus Numerical Rating Scale (PP-NRS) and the Worst Itch Numeric Rating Scale (WI-NRS) are single-item, patient-reported outcome measures for assessing the maximum severity of itch in people with pruritic skin disorders. The PP-NRS and WI-NRS assess the intensity of itch "at the worst moment during the previous 24 hours" on a scale of 0 ("no itch") to 10 ("worst itch imaginable").

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Moderate-to-severe	Adults: Initial dose of 600 mg SC followed by	See regimen
atopic dermatitis	300 mg SC every other week	



Indication	Dosing Regimen	Maximum Dose
	 Adolescents 6-17 years of age: Body weight 15 to < 30 kg: Initial dose of 600 mg SC followed by 300 mg SC every 4 weeks Body weight 30 kg to < 60 kg: Initial dose of 400 mg SC followed by 200 mg SC every other week Body weight ≥ 60 kg: Initial dose of 600 mg SC followed by 300 mg SC every other week Pediatrics 6 months - 5 years of age: Body weight 5 to < 15 kg: 200 mg SC every 4 weeks Body weight 15 to < 30 kg: 300 mg SC every 4 weeks 	
Moderate-to-severe asthma	 Adults and adolescents (12 years and older): Initial dose of 400 mg SC followed by 200 mg SC every other week; or Initial dose of 600 mg SC followed by 300 mg SC every other week For patients requiring concomitant oral corticosteroids or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated, start with an initial dose of 600 mg SC followed by 300 mg SC every other week Adolescents 6-11 years of age: Body weight 15 to < 30 kg: Initial dose and subsequent dose of 300 mg every four weeks Body weight ≥ 30 kg: Initial dose and subsequent dose of 200 mg SC every other week For pediatric patients (6 to 11 years old) with asthma and co-morbid moderate-to-severe atopic dermatitis, follow the recommended 	See regimen
CRSwNP	adolescent atopic dermatitis dosing, which includes an initial loading dose 300 mg SC every other week	300 mg every
		other week
ЕоЕ	Adult and pediatric patients ≥ 1 year of age, weight ≥ 15 kg:	300 mg/week



Indication	Dosing Regimen	Maximum Dose
	 Body weight 15 to < 30 kg: 200 mg SC every other week Body weight 30 to < 40 kg: 300 mg SC every other week Body weight ≥ 40 kg: 300 mg SC every 	
PN	week Initial dose of 600 mg SC followed by 300 mg SC every other week	See regimen
COPD	300 mg SC every other week	300 mg SC every other week
CSU	 Age ≥ 18 years: Initial (one-time) dose: 600 mg SC Maintenance dose: 300 mg SC every other week Age 12-17 years: Initial (one-time) dose: Weight ≥ 60 kg: 600 mg SC Weight 30 to < 60 kg: 400 mg SC Maintenance dose: Weight ≥ 60 kg: 300 mg SC every other week Weight 30 to < 60 kg: 200 mg SC every other week 	See regimen
BP	Initial dose of 600 mg SC followed by 300 mg SC every other week	See regimen

VI. Product Availability*

- Pre-filled syringes with needle shield for injection: 100 mg/0.67 mL, 200 mg/1.14 mL, 300 mg/2 mL
- Pre-filled pen: 200 mg/1.14 mL, 300 mg/2 mL

*The pre-filled pen is for use in adult and pediatric patients aged 2 years and older, while the pre-filled syringe is for use in adult and pediatric patients aged 6 months and older. In pediatric patients 12 to 17 years of age, Dupixent should be administered under the supervision of an adult. In pediatric patients 6 months to less than 12 years of age, Dupixent should be administered by a caregiver.

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS	Description
Codes	
C9399;	Unclassified drugs or biologicals
J3590	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created per March SDC (adapted from CP.PHAR.336 with the following revisions: for atopic dermatitis initial approval criteria, modified requirement from failure of two to only one topical corticosteroid; for Asthma initial approval criteria, modified criteria to require history of two exacerbations to require one exacerbation, added allowance for emergency room visit, removed intubation option, modified requirement of "LTRA" to "one additional asthma controller medication").	03.12.24	05.24
RT4: Updated approved indication to include pediatric patients aged 12 years and older for chronic rhinosinusitis with nasal polyps (CRSwNP). RT4: added newly approved COPD indication to criteria. For prurigo nodularis initial approval criteria, updated diagnosis criteria from "WI-NRS ≥ 7 on a scale of 0 to 10" to "Numeric rating scale ≥ 7 on a scale of 0 ("no itch") to 10 ("worst imaginable itch") (e.g., Peak Pruritus Numeric Rating Scale, Worst Itch-Numeric Rating Scale)" to align with Nemluvio criteria.	11.06.24	12.24
1Q 2025 annual review: for immunotherapy-related pruritus per NCCN, removed "refractory" for G3 pruritus, added requirement	12.02.24	02.25



Reviews, Revisions, and Approvals	Date	P&T Approval Date
for no response to 1 month of gabapentinoid therapy for severe pruritus, removed requirement for increased IgE level, and added indication for immunotherapy-related bullous dermatitis; references reviewed and updated. Per December SDC: for CRSwNP, changed intranasal corticosteroid redirection from double to single step.		
RT4: added new indication for CSU per updated prescribing information. Per SDC: for COPD, revised postbronchodilator FEV ₁ requirement from 30-70% to 20-80% to align with Nucala.	06.09.25	
RT4: added new indication for BP per updated prescribing information and P&T-approved clinical guidance.	06.25.25	

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.

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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.

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