blue of california

# dupilumab (DUPIXENT)

Diagnoses Considered for Coverage:

- Atopic dermatitis- moderate to severe
- Eosinophilic asthma- moderate to severe
- Corticosteroid-dependent asthma
- Chronic rhinosinusitis with nasal polyposis (CRSwNP)
- Eosinophilic esophagitis
- Prurigo nodularis (PN)

Coverage Criteria:

For diagnosis of moderate to severe atopic dermatitis:

| Initial request |
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| • Patient is at least 6 months old,<br>**and**<br>• Prescribed by or in consultation with a dermatologist, allergist, or immunologist,<br>**and**<br>• Diagnosis of moderate to severe atopic dermatitis with at least one of the following:<br>  ○ Investigator's Global Assessment (IGA) score of 3-4,<br>  ○ Eczema Area and Severity Index (EASI) score of at least 16,<br>  ○ Body surface area (BSA) of at least 10%<br>  ○ Severity Scoring of Atopic Dermatitis Index (SCORAD) score of at least 25,<br>**and**<br>• Inadequate response or intolerable side effect to TWO of the following, or contraindication to ALL of the following:<br>  ○ Medium, high, or very high potency topical corticosteroid, or<br>  ○ Topical calcineurin inhibitor [e.g. tacrolimus (Protopic) or pimecrolimus (Elidel)], or<br>  ○ Phototherapy, or<br>  ○ Systemic immunomodulating agents (e.g., methotrexate, azathioprine, mycophenolate mofetil, cyclosporine),<br>**and**<br>• Not used in combination with other JAK inhibitors (e.g., Cibinqo, Rinvoq), biologic immunomodulators (e.g. Adbry), or with other immunosuppressants (e.g. azathioprine, cyclosporine), **and**<br>• Dose does not exceed FDA label maximum. |

*Coverage Duration*: 16 weeks

| Reauthorization |
|---|
| • Patient had clinical response, **and**<br>• Not used in combination with other JAK inhibitors (e.g. Cibinqo, Rinvoq), biologic immunomodulators (e.g. Adbry), or with other immunosuppressants (e.g. azathioprine, cyclosporine), **and**<br>• Dose does not exceed FDA label maximum.<br><br>*Coverage Duration:* one year |

For diagnosis of moderate to severe eosinophilic asthma:

| Initial request |
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| • Patient is at least 6 years old, **and**<br>• Prescribed by or in consultation with a pulmonologist, allergist, or immunologist, **and**<br>• Eosinophil blood count of at least 150 cells/μL within last 6 weeks or at least 300 cells/μL within the last 12 months, **and**<br>• Asthma symptoms remain uncontrolled despite 3 months of treatment with a high-dose inhaled corticosteroid (ICS) in combination with long-acting beta agonist (LABA) or leukotriene receptor antagonists (e.g. montelukast, zafirlukast, zileuton), **and**<br>• Patient is not receiving this medication in combination with another biologic medication indicated for asthma treatment (e.g. Cinqair, Nucala, Fasenra, Xolair, Tezspire), **and**<br>• Dose does not exceed FDA label maximum, **and**<br>• Meets ONE of the following within the past year:<br>  • One or more acute asthma attacks requiring emergency care, or<br>  • One or more acute inpatient visits where asthma was the principal diagnosis, or<br>  • Use of chronic systemic steroids due to severe asthma OR two or more acute asthma exacerbations requiring oral systemic steroids.<br><br>*Coverage Duration*: 6 months |
| **Reauthorization** |
| • Patient is not receiving this medication in combination with another biologic medication indicated for asthma treatment (e.g. Cinqair, Fasenra, Nucala, Xolair, Tezspire), **and** |

- Dose does not exceed FDA label maximum, **and**
- Patient's asthma symptoms have improved or controlled while on Dupixent.

*Coverage Duration*: one year

For diagnosis of corticosteroid-dependent asthma:

| Initial request |
|---|
| • Prescribed by or in consultation with a pulmonologist, allergist, or immunologist, **and**<br>• Patient is at least 6 years old, **and**<br>• Asthma symptoms remain uncontrolled despite 3 months of treatment with a high-dose inhaled corticosteroid (ICS) in combination with long-acting beta agonist (LABA) or leukotriene receptor antagonists (e.g. montelukast, zafirlukast, zileuton), **and**<br>• Patient is currently taking maximally-tolerated systemic (oral, SQ/IM) corticosteroids (e.g. prednisone, prednisolone, dexamethasone), **and**<br>• Patient is not receiving this medication in combination with another biologic medication indicated for asthma treatment (e.g. Cinqair, Fasenra, Nucala, Xolair, Tezspire), **and**<br>• Dose does not exceed FDA label maximum, **and**<br>• Meets ONE of the following within the past year:<br>  • One or more acute asthma attacks requiring emergency care, **or**<br>  • One or more acute inpatient visits where asthma was the principal diagnosis, **or**<br>  • Two or more acute asthma exacerbations requiring an increase in systemic steroids<br><br>*Coverage Duration*: 6 months |
| Reauthorization |
| • Patient is not receiving this medication in combination with another biologic medication indicated for asthma treatment (e.g. Cinqair, Fasenra, Nucala, Xolair, Tezspire), **and**<br>• Patient's asthma symptoms have improved or controlled while on Dupixent, **and**<br>• Dose does not exceed FDA label maximum.<br><br>*Coverage Duration*: one year |

For diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP):

- Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist, **and**
- Patient has nasal polyps, **and**
- Patient is at least 18 years of age, **and**
- Inadequate response, intolerable side effect, or contraindication to an intranasal glucocorticoid, **and**
- Dose does not exceed FDA label maximum.

*Coverage Duration*: one year

For diagnosis of eosinophilic esophagitis (EoE):

Initial request

- Prescribed by or in consultation with an allergist, immunologist, or gastroenterologist, **and**
- Patient is at least 1 year of age, **and**
- One of the following:
  - Inadequate response or intolerable side effect with a proton pump inhibitor (PPI), or contraindication to all PPIs, or
  - Inadequate response or intolerable side effect with a guideline-supported intranasal glucocorticoid (e.g. inhaled fluticasone, inhaled budesonide), or contraindication to all glucocorticoids, **and**
- Dose does not exceed 300 mg given SQ every week.

*Coverage Duration*: 6 months

Reauthorization

- Patient had eosinophilic esophagitis symptom improvement while on Dupixent (e.g., histologic remission, dysphagia symptoms), **and**
- Dose does not exceed 300 mg given SQ every week.

*Coverage Duration*: one year

For diagnosis of prurigo nodularis (PN),

Initial request

- Prescribed by or in consultation with a dermatologist, **and**
- Patient is at least 18 years of age, **and**

- Inadequate response or intolerable side effects to two of the following, or contraindication to all of the following:
  - Medium, high, or very high potency topical or intralesional corticosteroids, or
  - Non-steroidal topical therapies [e.g., tacrolimus (Protopic), pimecrolimus (Elidel), capsaicin], or
  - Phototherapy, or
  - Systemic immunomodulating agents (e.g., methotrexate, cyclosporine, azathioprine, cyclophosphamide, thalidomide), **and**
- Dose does not exceed FDA label maximum.

*Coverage Duration*: 6 months

Reauthorization

- Prurigo nodularis symptoms have improved while on Dupixent (e.g., itch, lesions), **and**
- Dose does not exceed FDA label maximum.

*Coverage Duration*: one year

Coverage Duration: *See coverage criteria*

Effective Date:02/28/2024