Clinical Policy: Dupilumab (Dupixent)

Reference Number: IL.PHAR.336
Effective Date: 09.15.21
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Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

Dupilumab (Dupixent®) is an interleukin-4 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 patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).
- For the treatment of adult and pediatric patients aged 12 years and older, weighing at least 40 kg, with eosinophilic esophagitis (EoE).
- For the treatment of adult patients with prurigo nodularis (PN).

Limitation(s) of use: Not for the relief of acute bronchospasm or status asthmaticus

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;
2. Prescribed by or in consultation with a dermatologist or allergist;
3. Age ≥ 6 months;
4. Failure of one medium to very high potency topical corticosteroid within the past year and one of the following within the past 2 years (a, b, c, or d), unless contraindicated or clinically significant adverse effects are experienced:
    a. Generic Immunosuppressant (IS) if appropriate;

b. Topical calcineurin inhibitors (TCI);
c. Phototherapy (PT);
d. Phosphodiesterase-4 inhibitor (PDE-4)

5. Dupixent is not prescribed concurrently with Cinqair®, Fasenra®, Nucala®, or Xolair®;
6. Dose does not exceed the following:
   a. Initial (one-time) dose:
      i. Age ≥ 18 years, weight ≥ 60 kg, or age 6-17 years and weight 15 to < 30 kg: 600 mg;
      ii. Age 6-17 years and weight 30 to < 60 kg: 400 mg;
   b. Maintenance dose:
      i. Age ≥ 18 years or weight ≥ 60 kg: 300 mg every other week;
      ii. Age 6-17 years and weight 30 to < 60 kg: 200 mg every other week;
      iii. 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, b or c):
   a. Absolute blood eosinophil count ≥ 150 cells/mcL within the past 3 months;
   b. Oral corticosteroid dependent asthma;
   c. Member has a Forced Expiratory Volume (FEV1) that is less than 80% predicted for adults or less than 90% for adolescents and has been treated consistently with a leukotriene modifier OR medium-high/max-tolerated ICS + controller OR max-tolerated ICS/LABA combo;
2. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist;
3. Age ≥ 6 years;
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. Dose does not exceed the following:
   a. Initial (one-time) dose for age ≥ 12 years: 600 mg;
   b. Maintenance dose:
      i. Age ≥ 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
2. Prescribed by or in consultation with an allergist, pulmonologist, or otolaryngologist;
3. Age ≥ 18 years;
4. One of the following
   a. Member has had prior nasal surgery OR

b. Member CRSwNP is inadequately controlled by medical therapy with two of the following:
   1. Intranasal corticosteroids (INS) within the past year;
   2. Systemic corticosteroid therapy (SCS);
   3. Nasal nebulized solution of budesonide;
   4. Contraindication or intolerance to SCS;
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 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 years;
4. Weight ≥ 15 kg;
5. Member does not have hypereosinophilic syndrome or eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome);
6. Failure of the following (a and b), unless clinically significant adverse effects are experienced, or both are contraindicated:
   a. Use of Proton pump inhibitor for 8 weeks (see Appendix B for examples);
   b. Topical glucocorticocoid (fluticasone using MDI without a spacer or budesonide administered as an oral slurry);
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 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):
   a. Worst Itch-Numeric Rating Scale (WI-NRS) ≥ 7 on a scale of 0 ("no itch") to 10 ("worst imaginable itch");
   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 ≥ 18 years;
4. Failure of a ≥ 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. Immunotherapy-related Pruritus (off-label) (must meet all)**:**
1. Diagnosis of immune checkpoint inhibitor-related severe (G3) pruritus that is refractory (*see Appendix E*);
2. Member has an increased IgE level;
3. Prescribed by or in consultation with an oncologist;
4. Dupixent is not prescribed concurrently with Cinqair, Fasenra, Nucala, Xolair, or Tezspire;
5. 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

G. 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: CP.PMN.255 for Medicaid; 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: CP.PMN.16 for Medicaid; 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: CP.PMN.53 for Medicaid.

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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 ≥ 18 years or weight ≥ 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;

5. Age 6 months to 5 years and weight 15 to < 30 kg: 300 mg every 4 weeks

Approval duration:
Medicaid– 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 LTRA) 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 ≥ 12 years: 300 mg every other week;
   b. Age 6-11 years and weight ≥ 30 kg: 200 mg every other week;
6. Age 6-11 years and weight 15 to < 30 kg: 300 mg every 4 weeks

Approval duration:
Medicaid – 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:
Medicaid – 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);

Approval duration: Medicaid – 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:
Medicaid – 12 months

F. 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

G. 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: CP.PMN.255 for Medicaid; 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: CP.PMN.16 for Medicaid; 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: CP.PMN.53 for Medicaid.

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 – CP.PMN.53 for Medicaid or evidence of coverage documents.

B. Acute bronchospasm or status asthmaticus.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CRSwNP: chronic rhinosinusitis with nasal polyposis
FDA: Food and Drug Administration
GINA: Global Initiative for Asthma
ICS: inhaled corticosteroid
LABA: long-acting beta$_2$ agonist
LTRA: leukotriene modifier
PDC: proportion of days covered

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		
Very High Potency Topical Corticosteroids		
augmented betamethasone 0.05% (Diprolene® AF) cream, ointment, gel, lotion	Apply topically to the affected area(s) BID	Varies
clobetasol propionate 0.05% (Temovate®) cream, ointment, gel, solution		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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 Corticosteroids		
amcinonide 0.1% ointment, lotion	Apply topically to the affected area(s) BID Varies	
augmented betamethasone 0.05% (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		
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 Corticosteroids		
clocortolone pivalate 0.1% cream	Apply topically to the affected area(s) BID	Varies
desoximetasone 0.05%, 0.25% (Topicort ®) cream, ointment, gel, spray		
fluocinolone acetonide 0.025% (Synalar®) cream, ointment		
flurandrenolide 0.05% lotion, ointment (Cordran®)		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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® (pimecrolimus)	Children ≥ 2 years and adults: Apply a thin layer topically to affected skin BID. Treatment should be discontinued if resolution of disease occurs.	Varies
Eucrisa® (crisaborole)	Apply to the affected areas BID	Varies
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		
ICS (medium – high dose)		
Qvar® (beclomethasone)	> 200 mcg/day 40 mcg, 80 mcg per actuation 1-4 actuations BID	4 actuations BID
budesonide (Pulmicort®)	> 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco® (ciclesonide)	> 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID
Aerospan® (flunisolide)	> 320 mcg/day 80 mcg per actuation 2-4 actuations BID	2 actuations BID
Flovent® (fluticasone propionate)	> 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	>220 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation	2 inhalations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	1-2 actuations QD to BID	
LABA		
Serevent® (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
Combination products (ICS + LABA)		
Dulera® (mometasone/ formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
Advair® (fluticasone/ salmeterol)	Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation 1 actuation BID	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick®)	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID
Symbicort® (budesonide/ formoterol)	80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation 2 actuations BID	2 actuations BID
LTRA		
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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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

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.

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

- 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.
- During 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.
- The 2019 Global Initiative for Asthma (GINA) guidelines for difficult-to-treat and severe asthma recommend Dupixent be considered as adjunct therapy for patients 12 years of age and older with exacerbations or poor symptom control despite taking at least high dose ICS/LABA and who have allergic or eosinophilic biomarkers or need maintenance oral corticosteroids. Per 2020 GINA guidelines, Dupixent may also be considered if the patient is uncontrolled on Step 4 treatment (medium dose ICS/LABA).

- 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/m/fasenra-eosinophil-calculator.html

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
  - G1: Mild or localized
  - G2: Moderate. Intense or widespread; intermittent; skin changes from scratching (e.g., edema, papulation, excoriations, lichenification, oozing/crusts); limiting instrumental ADLs
  - G3: Severe. Intense or widespread; constant; limiting self-care ADLs or sleep

V. Dosage and Administration

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

Indication	Dosing Regimen	Maximum Dose
	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 100 mg SC every other week or 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 adolescent atopic dermatitis dosing, which includes an initial loading dose	
CRSwNP	300 mg SC every other week	300 mg every other week

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

Indication	Dosing Regimen	Maximum Dose
	Adolescents 6-11 years of age: • Body weight 15 to < 30 kg: Initial dose and subsequent dose of 100 mg SC every other week or 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 adolescent atopic dermatitis dosing, which includes an initial loading dose	
CRSwNP	300 mg SC every other week	300 mg every other week

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 only for use in adults and adolescents aged 12 years and older. In adolescents 12 years of age and older, it is recommended that Dupixent be given by or under the supervision of an adult. Dupixent pre-filled syringe should be given by a caregiver in children 6-11 years of age.*

VII. References

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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 Codes	Description
C9399; J3590	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy		
Policy created, adapted from CP.PHAR.336 Dupilumab (Dupixent) for HFS PDL.	9.15.21	
4Q2021: Updated per HFS PDL Criteria: For **Chronic Rhinosinusitis with Nasal Polyposis removed immunologist and added pulmonologist**	11.11.21	
1Q2022 Annual review: expanded age to 6+ years old for asthma and added new 100 mg prefilled syringe formulation; added "Acute bronchospasm or status asthmaticus" to section III as	3.18.22	

Reviews, Revisions, and Approvals	Date	P&T Approval Date
indications for which coverage is not authorized per PI; references reviewed and updated.		
Added EoE criteria per HFS PDL	11.13.22	
For AD indication: clarified that topical corticosteroids requirement is for corticosteroids of different molecular identities and expanded examples of medium to very high potency topical corticosteroids in Appendix B; removed low potency topical corticosteroids from Appendix B; references reviewed and updated	1.6.23	
Added Prurigo Nodularis to Initial and Continuing criteria, further aligned criteria to HFS PDL; template changes applied to initial and continuing criteria	10.20.23	
Initial criteria updated to align with MDN.CP.PHAR.336	12.1.23	
Initial criteria for EoE updated per recent FDA label change; off label immunotherapy related pruritis indication added	2.11.24	
Added Appendix E	5.28.24	

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.