MEDICATION POLICY

Generic Name: Dupilumab

Therapeutic Class or Brand Name: Dupixent®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 8/4/17 **Date Last Reviewed/Revised:** 9/8/17

GPI Code: 9027302000

Prior Authorization Criteria (may be considered medically necessary when criteria I through VII are met):

I. Documented diagnosis of moderate-to-severe atopic dermatitis.

II. Documented trial and failure of, intolerance, or contraindication to two high to very high potency topical corticosteroids (i.e. betamethasone dipropionate augmented cream or ointment 0.05%, triamcinolone acetonide cream or ointment 0.5%, etc.).

III. Documented trial and failure of, intolerance, or contraindication to one topical calcineurin inhibitor (i.e. tacrolimus, etc.).

IV. Documented trial and failure of, intolerance, or contraindication to one systemic immunosuppressive drug (i.e. cyclosporine, azathioprine, methotrexate).

V. Documentation that the patient has Body Surface Area (BSA) involvement of at least 10% OR that the atopic dermatitis is impairing the patient's activities of daily living (ADLs).

VI. Minimum age requirement: 18 years old.

VII. Prescribing physician must be a dermatologist, allergist, or immunologist.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- 4 syringes in the first 28 days, then 2 syringes every 28 days thereafter.

Approval Length:

- **Authorization:** 6 months.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing that current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

References:

1. https://www.aad.org/practicecenter/quality/clinical-guidelines/atopic-dermatitis.
2. https://www.regeneron.com/sites/default/files/Dupixent_FPI.pdf.
3. Medi-Span.
4. http://blue.regence.com/trgmedpol/drugs/dru493.pdf.
5. https://tuftshealthplan.com/documents/providers/guidelines/pharmacy-medical-necessity-guidelines/dupixent.
6. http://www.bcbsnc.com/assets/services/public/pdfs/formulary/dupixent_criteria.pdf.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
9/8/2017	1. **Changed** "II. Documented trial and failure of, intolerance, or contraindication to one medium to very high potency topical corticosteroid (i.e. betamethasone valerate cream or ointment 0.1%, betamethasone dipropionate augmented ointment 0.05%, etc.)" **to** "II. Documented trial and failure of, intolerance, or contraindication to two high to very high potency topical corticosteroids (i.e. betamethasone dipropionate augmented cream or ointment 0.05%, triamcinolone acetonide cream or ointment 0.5%, etc.)" **under Prior Authorization Criteria**.