**Prior Authorization Criteria**

**Dupixent® (dupilumab) PA Criteria FOR ATOPIC DERMATITIS:**

**Dupixent® (dupilumab)** is an interleukin-4 receptor alpha antagonist FDA approved for the treatment of moderate-to-severe atopic dermatitis in patients 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.*

ICD-10 code(s): _______________________________________________________________________________________

Submission of medical records or prescription claims history documenting the following requirements for the indications below is **required upon request.**

**Dupixent FOR ATOPIC DERMATITIS** may be approved based on **ALL** of the following criteria:

**INITIAL AUTHORIZATION: (will be issued for 6 months)**

- Yes  □ No  Diagnosis of moderate to severe chronic atopic dermatitis;
  -AND-  
- Yes  □ No  Age of patient is within the age range as recommended by the FDA label;
  -AND-  
- Yes  □ No  Prescribed by or in consultation with an allergist, dermatologist or immunologist;
  -AND-  
- Yes  □ No  Patient is not receiving Dupixent in combination with another biologic medication for the treatment of atopic dermatitis [e.g., Enbrel (etanercept), Remicade/Inflectra (infliximab), Xolair (omalizumab), Rituxan (rituximab)];
  -AND-  
- Yes  □ No  Patient has a documented failure, intolerance, or contraindication to **ONE** of the three following scenarios:

  - Yes  □ No  **1. For moderate atopic dermatitis: BOTH of the following:**
    - One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in last 365 days);
      -and-
    - Either one topical calcineurin inhibitor [Elidel/pimecrolimus or Protopic/tacrolimus] -or- Eucrisa (crisaborole) used for ≥ 4 week trial (1 claim in the last 90 days);
      -OR-
  - Yes  □ No  **2. For severe atopic dermatitis: BOTH of the following:**
    - One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in the last 365 days);
      -and-
    - One topical calcineurin inhibitor [Elidel/pimecrolimus or Protopic/tacrolimus] used for ≥ 4 week trial (1 claim in the last 90 days);
3. Patient is currently on Dupixent therapy;

-OR-

☐ Yes  ☐ No

-AND-

☐ Yes  ☐ No  Prescribed dose does not exceed the following:
- Initial (one-time) dose: 600 mg
- Maintenance dose: 300 mg every other week

REAUTHORIZATION: (will be issued for 12 months)

☐ Yes  ☐ No  Patient continues to meet initial authorization criteria;

-AND-

☐ Yes  ☐ No  Prescribed dose does not exceed the following;
- Maintenance dose: 300 mg every other week;

-AND-

☐ Yes  ☐ No  Positive clinical response to Dupixent therapy (e.g., reduction in body surface area, reduction in pruritus severity).