Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

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);

-OR-

☐ Yes ☐ No 3. Patient is currently on Dupixent therapy;

-AND-

☐ Yes ☐ No Prescribed dose does not exceed the following:

- Initial (one-time) dose: 600 mg
- Maintenance dose: 300 mg every other week

<u>REAUTHORIZATION</u>: (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).