Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

Dupixent® (dupilumab) PA Criteria FOR Chronic Rhinosinusitis with Nasal Polyposis:

Dupixent® (dupilumab) is an interleukin-4 receptor alpha antagonist indicated as an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

ICD-10 code(s):_____

INITIAL AUTHORIZATION: Authorization will be issued for 6 months.

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

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

☐ 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, immunologist, or otolaryngologist;

-AND-

☐ Yes ☐ No Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids unless contraindicated or history of intolerance;

-AND-

☐ Yes ☐ No Patient is **not** receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)];

-AND-

☐ Yes ☐ No Dupixent dose does not exceed 300 mg every other week.

-AND-

1. Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by **ALL** of the following:

☐ Yes ☐ No a. **Two or more** of the following symptoms for ≥ 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction/congestion
- Decreased or absent sense of smell
- Facial pressure or pain

-AND-

☐ Yes ☐ No b. Presence of nasal polyposis by direct examination, endoscopy, or sinus CT scan

-AND-

☐ Yes ☐ No c. **<u>One</u>** of the following:

- Patient has required prior sino-nasal surgery,

-OR-

- Patient has required systemic corticosteroids in the previous 2 years, unless contraindicated or documented intolerance history;

-AND-

☐ Yes ☐ No Inadequate response at appropriate doses to treat nasal polyposis after trial of **<u>all</u>** of the following agents/classes of agents unless contraindicated or intolerance for at least 8 weeks duration:

- Nasal saline irrigations
- Intranasal corticosteroids
- Leukotriene modifiers

<u>-OR-</u>

(2) <u>All</u> of the following:

☐ Yes ☐ No Diagnosis of CRSwNP

-AND-

☐ Yes ☐ No Patient is currently on Dupixent therapy;

<u>REAUTHORIZATION:</u> will be issued for 12 months

Dupixent may be approved based on **<u>all</u>** of the following criteria:

☐ Yes ☐ No Documentation of positive clinical response to Dupixent therapy

-AND-

☐ Yes ☐ No Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids (unless contraindicated or intolerant)

-AND-

☐ Yes ☐ No Patient is **<u>not</u>** receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]

☐ Yes ☐ No Dupixent dose does not exceed 300 mg every other week.