**Prior Authorization Criteria**

**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. **One** 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 **both** of the following agents/classes of agents unless contraindicated or intolerance for at least 8 weeks duration:
  - Nasal saline irrigations  
  - Intranasal corticosteroids  

-OR-

(2) **All** of the following:

☐ Yes  ☐ No Diagnosis of CRSwNP  
-AND-

☐ Yes  ☐ No Patient is currently on Dupixent therapy;

**REAUTHORIZATION: will be issued for 12 months**

**Dupixent** may be approved based on **all** 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 **not** 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.