Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

Dupixent® (dupilumab) PA Criteria FOR EOSINOPHILIC ESOPHAGITIS:

Dupixent® (dupilumab) is an interleukin-4 receptor alpha antagonist FDA approved for the treatment of eosinophilic esophagitis (EoE) in adult and pediatric patients aged 12 years and older, weighing at least 40 kg.

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

INITIAL AUTHORIZATION: (will be issued for 6 months)

☐ Yes ☐ No Diagnosis of eosinophilic esophagitis confirmed by ≥ 15 intraepithelial eosinophils per high-power field (eos/hpf) on endoscopic biopsy;

-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 a gastroenterologist, immunologist or allergist;

-AND-

☐ Yes ☐ No Patient body weight is at least 40 kg;

-AND-

☐ Yes ☐ No Member does not have hypereosinophilic syndrome or eosinophilic granulomatosis with polyangiitis (Churg-Strauss syndrome);

-AND-

☐ Yes ☐ No Patient has a documented failure, intolerance, or contraindication to a proton pump inhibitor;

-AND-

☐ Yes ☐ No Dupixent is not prescribed concurrently with Cinqair, Fasenra, Nucala, Tezspire, or Xolair;

-AND-

☐ Yes ☐ No Dose does not exceed 300 mg every week.

REAUTHORIZATION: (will be issued for 12 months)

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

-AND-

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

-AND-

☐ Yes ☐ No Prescribed dose does not exceed 300 mg once a week.