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.*

Submission of medical records or prescription claims history documenting the following requirements for the indications below is **required upon request**. Trials will be based on prescription claims and use of medication samples will NOT be accepted as medical justification.

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

INITIAL AUTHORIZATION: (will be issued for 6 months)

1. Diagnosis of moderate to severe chronic atopic dermatitis;

-AND-

2. Affected body surface area is greater than or equal to 10%;

-AND-

3. Age of patient is within the age range as recommended by the FDA label;

-AND-

4. Prescribed by or in consultation with an allergist, dermatologist, or immunologist;

-AND-

5. Patient is **not** receiving Dupixent in combination with another biologic medication or JAK inhibitor for the treatment of atopic dermatitis [e.g., Enbrel (etanercept), Remicade/Inflectra (infliximab), Xolair (omalizumab), Rituxan (rituximab), Adbry (tralokinumab-ldrm), Opzelura (topical ruxolitinib)];

-AND-

6. Patient meets ONE of the following four scenarios:

A) **For <u>moderate</u> atopic dermatitis: BOTH of the following:**

- One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in last 90 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-

B) **For <u>severe</u> atopic dermatitis: BOTH of the following:**

- One preferred medium to very-high potency topical corticosteroid ≥ 2 week trial (1 claim in the last 90 days);

-and-

- One topical calcineurin inhibitor [Elidel /pimecrolimus or Protopic/tacrolimus] used for ≥ 4 week trial (1 claim in the last 90 days);

-OR-

C) Prescriber provides detailed clinical justification to why topical therapies are inadvisable with supporting documentation (e.g., failure, intolerance, or contraindication to scenarios outlined in 6A or 6B);

-OR-

D) Patient is currently on Dupixent therapy (not including the use of samples);

-AND-

7. 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)

1. Patient continues to meet initial authorization criteria; **AND**

2. Prescribed dose does not exceed a maintenance dose of 300 mg every other week; **AND**

3. Positive clinical response to Dupixent therapy (e.g., reduction in body surface area, reduction in pruritus severity).