Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	Dupixent (dupilumab)	Policy #:	2597P

Purpose of the Policy

The purpose of this policy is to establish the criteria for coverage of Dupixent.

Statement of the Policy

Health Alliance Medical Plans will approve the use of Dupixent under the specialty pharmacy benefit when the following criteria have been met.

Criteria

1. **Coverage Criteria for Atopic Dermatitis**
   - 1.1 See Atopic Dermatitis Immunomodulator Therapies Policy
2. **Coverage Criteria for Asthma**
   - 2.1 Documented diagnosis of eosinophilic phenotype severe asthma
     - Peripheral blood eosinophil count of 150 cells per microliter within the previous 6 weeks
   - 2.2 Prescribed by an allergist (allergy specialist), immunologist (immune system doctor), or pulmonologist (lung doctor)
   - 2.3 Age 6 years or older
   - 2.4 Documented concurrent use with one of the following:
     - An inhaled corticosteroid (ICS) therapy such as Asmanex, Pulmicort or QVAR with one additional therapy such as montelukast with lack of asthma control
     - A combination inhaled corticosteroid/long acting beta2 agonist (ICS/LABA) inhaler such as Symbicort or Dulera with lack of asthma control
3. **Coverage Criteria for Glucocorticoid Dependent Asthma**
   - 3.1 Documented history of asthma management requiring the daily use of prednisone or prednisolone equivalents of 5-35mg daily over the previous 6 months
   - 3.2 Prescribed by an allergist (allergy specialist), immunologist (immune system doctor), or pulmonologist (lung doctor)
   - 3.3 Age 12 years or older
   - 3.4 Documented concurrent use with one of the following:
     - An inhaled corticosteroid (ICS) therapy such as Asmanex, Pulmicort or QVAR with one additional therapy such as montelukast with lack of asthma control
     - A combination inhaled corticosteroid/long acting beta2 agonist (ICS/LABA) inhaler such as Symbicort or Dulera with lack of asthma control
4. **Coverage Criteria for Asthma in Combination with Atopic Dermatitis**
   - 4.1 Coverage requires that member meets the above criteria for either asthma or atopic dermatitis
5. **Coverage Criteria for Rhinosinusitis with Nasal Polyposis**
   - 5.1 Documented diagnosis of rhinosinusitis with nasal polyps
   - 5.2 Prescribed by an otolaryngologist (ear, nose and throat specialist), allergist (allergy specialist), or immunologist (immune system doctor)
   - 5.3 Age 12 years or older

5.4 Documented failure, intolerance, or contraindication to intranasal glucocorticoids (such as fluticasone)

6. **Coverage Criteria for Eosinophilic Esophagitis (EoE)**
   6.1 Documented diagnosis of EoE confirmed by biopsy
   6.2 Age 1 year or older and weighs at least 15kg
   6.3 Prescribed by or in consultation with an allergist (allergy doctor) or gastroenterologist (stomach doctor)
   6.4 Documented history of at least 2 episodes of difficulty swallowing solids per week
7. **Coverage Criteria for Prurigo Nodularis**
   7.1 Documented diagnosis of prurigo nodularis
   7.2 Age 18 years or older
   7.3 Prescribed by or in consultation with a dermatologist (skin doctor)
   7.4 Documented severe itching or very severe itching with multiple prurigo nodularis lesions
   7.5 Documentation of trial, failure, or contraindication to topical corticosteroids
8. **Coverage Criteria for COPD**
   8.1 Documented diagnosis of chronic obstructive pulmonary disease (COPD) with both of the following:
      - Presence of type 2 inflammation evidenced by blood eosinophil count ≥300 cells per microliter
      - Post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70 while on an optimized therapy
   8.2 Age 18 years or older
   8.3 Prescribed by or in consultation with a pulmonologist
   8.4 Documented concurrent use with one of the following:
      - Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA)
      - If ICS are contraindicated, a LAMA and a LABA
   8.5 Documentation to support one of the following within the past 12 months:
      - At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once
      - COPD related hospitalization and patient experiences dyspnea during everyday activities
9. **Approval Period**
   9.1 Initial Approval: 12 months
   9.2 Re-approval: 12 months with documented improvement
      - For asthma use, improvement is indicated by reduction in frequency of exacerbations, reduced used of controller medications, reduction in asthma symptoms, or increase in FEV1 from pretreatment baseline

CPT Codes	

HCPCS Codes	

References

1. Dupixent (dupilumab) [prescribing information]. Tarrytown, NY: Regeneron Pharmaceuticals; September 2024.
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3. Rank MA, Chu DK, Bognanni A, et al. The Joint Task Force on Practice Parameters GRADE guidelines for the medical management of chronic rhinosinusitis with nasal polyposis. J Allergy Clin Immunol. 2023 Feb;151(2):386-398.
4. Rabe KF, Nair P, Brusselle G, Maspero JF, Castro M, Sher L, et al. Efficacy and safety of dupilumab in glucocorticoid-dependent severe asthma. New England Journal of Medicine.
5. Hirano I, Chan ES, Rank MA, et al. AGA Institute and the Joint Task Force on Allergy-Immunology Practice Parameters Clinical Guidelines for the Management of Eosinophilic Esophagitis.
6. Elmariah S, Kim B, Berger T, et al. Practical approaches for diagnosis and management of prurigo nodularis: United Stsates expert panel consensus. J Am Adad Dermatol 2021; 84:747.
7. 7. Bhatt SP, Rabe KF, Hanania NA, et al; BOREAS Investigators. Dupilumab for COPD with type 2 inflammation indicated by eosinophil counts. N Engl J Med. 2023;389(3):205-214.

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