

## New Hampshire Medicaid Fee-for-Service Program

### Dupilumab® (dupilumab) Criteria

Approval Date: August 7, 2020

#### Indications

Dupilumab\* is an interleukin-4 (IL-4)  $\alpha$ -antagonist indicated as an add-on maintenance treatment in patients with moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid-dependent asthma, for the treatment of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies or when those therapies are inadvisable, and an add-on maintenance treatment for adults with inadequately controlled chronic rhinosinusitis with nasal polyposis.

#### Medications

Brand Names	Generic Names	Dosage
Dupilumab®	dupilumab	300 mg/2 mL, 200 mg/1.14 mL 300 mg/2 mL single-dose prefilled syringe with needle shield

#### Criteria for Approval for Asthma

1. Prescriber is an allergist, immunologist, or pulmonologist (or one of these specialists has been consulted); **AND**
2. Patient is  $\geq 12$  years old; **AND**
3. Diagnosis of moderate or severe, persistent asthma; **AND**
4. Inadequately controlled asthma despite medium-to-high doses of corticosteroid (inhaled or oral) in combination with:
  - a. Long-acting beta agonist; **OR**
  - b. Leukotriene receptor agonist; **OR**
  - c. Theophylline; **AND**
5. History of positive skin test or *in vitro* test to perennial aeroallergen or eosinophilic phenotype; **AND**
6. Non-smoker status



## Length of Authorization

Initial six months, extended approval for 12 months if additional criteria are met.

## Criteria for 12-Month Renewal

1. Approved for initial six-month trial; **AND**
2. Clinical improvement was seen.

## Criteria for Denial

1. Above criteria are not met; **OR**
2. If being used for peanut allergy only; **OR**
3. Patient is an active smoker; **OR**
4. Failure to be compliant with current regimen as evidenced by review of claims history; **OR**
5. For asthma diagnosis only, no claims history of inhaled corticosteroid, long-acting beta agonist, leukotriene receptor, antagonists or theophylline in the last 120 days for new prescriptions only.

## Criteria for Approval for Atopic Dermatitis

1. Prescriber is a dermatologist (or one has been consulted); **AND**
2. FDA-approved indication and age:
  - a. **Dupixent® (dupilumab\*)**: Treatment of adults and children  $\geq 12$  years old with moderate to severe atopic dermatitis, whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable; may be used with or without topical corticosteroids

**AND**

3. Patient has a defined failure or contraindication or intolerance to a trial of topical corticosteroids. In general, a trial constitutes two weeks for high-potency topical corticosteroids (e.g., diflorasone diacetate) and four weeks for low-potency topical corticosteroids (e.g., hydrocortisone acetate); **AND**
4. Prescribed utilization is for short-term (up to six consecutive weeks at a time) therapy or for non-continuous intermittent therapy (up to one year in duration).



**Length of Approval:** Two months

**Renewal:** Six months

### Criteria for Denial

1. Failure to meet criteria for approval; **OR**
2. Treatment of psoriasis; **OR**
3. Treatment of infected atopic dermatitis; **OR**
4. Treatment of Netherton's syndrome.

### Criteria for Approval for chronic rhinosinusitis with nasal polyposis

1. Prescriber is an ear, nose and throat (ENT) specialist (or one has been consulted); **AND**
2. Patient is  $\geq 18$  years old; **AND**
3. Diagnosis of chronic rhinosinusitis with nasal polyposis; **AND**
4. Dupilumab will be used as an add-on maintenance treatment; **AND**
5. Patient has had prior sino-nasal surgery or treatment with, or who were ineligible to receive or were intolerant to, systemic corticosteroids within the past 2 years; **OR**
6. Patient's symptoms are not adequately controlled with intranasal steroids.

### Length of Authorization

**Length of Approval:** Six months

**Renewal:** Twelve months

### Criteria for Denial

1. Failure to meet criteria for approval; **OR**
2. Patients with chronic rhinosinusitis without nasal polyposis.

### Criteria for Renewal

1. Clinical improvement was seen; **AND**
2. Dupilumab will be used as an add-on maintenance treatment.



## References

Available upon request.

## Revision History

Reviewed by	Reason for Review	Date Approved
Pharmacy & Therapeutic DUR Board	New	06/30/2020
Commissioner Designee	Approval	8/7/2020