I. Medication Description

Dupilumab is a human monoclonal IgG4 antibody that inhibits interleukin-4 (IL-4) and interleukin-13 (IL-13) signaling by specifically binding to the IL-4Ra subunit shared by the IL-4 and IL-13 receptor complexes. Dupilumab inhibits IL-4 signaling via the Type I receptor and both IL-4 and IL-13 signaling through the Type II receptor.

Inflammation is an important component in the pathogenesis of asthma, atopic dermatitis, and chronic rhinosinusitis with nasal polyposis (CRSwNP). Multiple cell types that express IL-4Ra (e.g., mast cells, eosinophils, macrophages, lymphocytes, epithelial cells, goblet cells) and inflammatory mediators (e.g. histamine, eicosanoids, leukotrienes, cytokines, chemokines) are involved in inflammation. Blocking IL-4Ra with dupilumab inhibits IL-4 and IL-13 cytokine-induced inflammatory responses, including the release of proinflammatory cytokines, chemokines, nitric oxide, and IgE; however, the mechanism of dupilumab action in asthma has not been definitively established.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage of Dupixent is available for the following conditions when the listed criteria are met:

- Moderate-to-severe atopic dermatitis:
  - Medication is prescribed by an allergist, immunologist, or dermatologist AND
  - Member is at least 12 years of age AND
  - Member has atopic dermatitis involvement estimated to be ≥ 10% of the body surface area (BSA) according to the prescribing physician AND
  - Member has tried at least one of the following systemic medications: oral corticosteroid, intramuscular corticosteroid, oral cyclosporine, oral azathioprine, oral methotrexate, or oral mycophenolate mofetil AND
  - Member has used at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid (or use is shown to be contraindicated) AND
  - Member has tried a topical calcineurin inhibitor (unless use is contraindicated).

- Moderate-to-severe asthma:
  - Medication is prescribed by an allergist/immunologist, or pulmonologist AND
o Member is at least 12 years of age AND
o Member has a history of one or more exacerbations resulting in either emergency department visits or need for pulse oral or IV corticosteroids in the past 12 months AND
o These exacerbations occurred despite regular use of high-dose inhaled corticosteroids plus an additional controller(s) AND
o One of the following diagnoses have been documented:
  ▪ eosinophilic asthma OR
  ▪ oral corticosteroid-dependent asthma AND
o Coverage of Dupixent is not available in combination with Xolair.

- Chronic rhinosinusitis with nasal polyposis (CRSwNP):
  o Medication is prescribed by an allergist, immunologist, ENT specialist, or pulmonologist AND
  o Member is at least 18 years of age AND
  o Member has chronic rhinosinusitis symptoms (e.g. nasal congestion, nasal drainage, facial pain/pressure, reduction/loss of smell) AND
  o Member has evidence of nasal polyposis by direct examination, endoscopy, or imaging studies AND
  o Member’s condition has been inadequately controlled with an intranasal corticosteroid therapy or surgery (where appropriate) AND
  o Member will continue receiving intranasal corticosteroid therapy (unless contraindicated) AND
  o Medication will be used as an add-on maintenance treatment.

IV. Quantity Limitations

Coverage is available as follows:

- For the treatment of moderate-to-severe atopic dermatitis:
  o Adolescents (less than 60 kg):
    ▪ Up to four 200 mg syringes are covered in the first month to accommodate induction dosing
    ▪ Up to two 200 mg syringes are covered in subsequent months to accommodate maintenance dosing OR
  o Adolescents (60 kg or more) or adults (including members with co-morbid moderate-to-severe atopic dermatitis):
    ▪ Up to four 300 mg syringes are covered in the first month to accommodate induction dosing
    ▪ Up to two 300 mg syringes are covered in subsequent months to accommodate maintenance dosing.

- For the treatment of moderate-to-severe asthma in adolescents and adults:
  o Up to four 200 mg syringes are covered in the first month to accommodate induction dosing
  o Up to two 200 mg syringes are covered in subsequent months to accommodate maintenance dosing OR
  o Up to four 300 mg syringes are covered in the first month to accommodate induction dosing
  o Up to two 300 mg syringes are covered in subsequent months to accommodate maintenance dosing.
• For the treatment of moderate-to-severe oral corticosteroid-dependent asthma:
  o Up to four 300 mg syringes are covered in the first month to accommodate induction dosing
  o Up to two 300 mg syringes are covered in subsequent months to accommodate maintenance dosing.
• For the treatment of CRSwNP:
  o Up to two 300 mg syringes are covered per 4 weeks.

V. Coverage Duration

• For the treatment of atopic dermatitis or asthma:
  o Coverage is available for 12 months and may be renewed.
• For the treatment of CRSwNP:
  o Coverage is available for 6 months and may be renewed.

VI. Coverage Renewal Criteria

Coverage can be renewed based upon the following criteria:
• Stabilization of disease or in absence of disease progression AND
• Absence of unacceptable toxicity from the drug

VII. Billing/Coding Information

• Available as 300 mg/2ml and 200 mg/1.14 ml pre-filled syringes.
• Available in cartons containing 2 prefilled syringes.

VIII. Summary of Policy Changes

• 7/19/17: new policy
• 10/11/17: removed time frame for trials of systemic medications and topical calcineurin inhibitor; quantity limitations updated
• 11/1/18: no policy changes
• 2/15/19: criteria for asthma indication added
• 8/15/19: updated member age and dosing information
• 11/15/19: added criteria for the treatment of nasal polyps; updated quantity limitations and renewal criteria

IX. References

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.