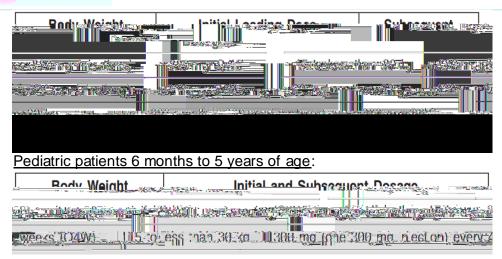


PHARMACY POLICY STATEMENT Marketplace

DRUG NAME	Dupixent (dupilumab)
BENEFIT TYPE	Pharmacy





If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Chart notes demonstrate improvement of signs and symptoms such as fewer flares, less itching/erythema, improved quality of life, etc.

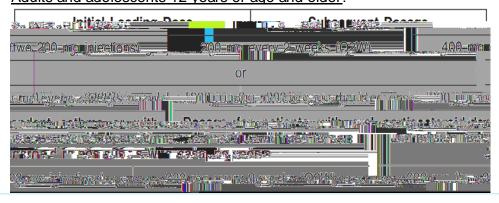
If all the above requirements are met, the medication will be approved for an additional 12 months.

Asthma

For initial authorization:

- 1. Member must be 6 years of age or older: AND
- Medication must be prescribed by or in consultation with a pulmonologist, immunologist or allergist;
- 3. Member has **ONE** of the following:
 - a) Severe eosinophilic asthma including:
 - i) Blood eosinophil count of at least 150 cells/µL; AND
 - ii) At least **TWO** documented severe asthma exacerbations requiring oral corticosteroids (OCS), or at least **ONE** requiring hospitalization, within last year; OR
 - b) Oral corticosteroid (OCS) dependent asthma; AND
- 4. Member's asthma has been inadequately controlled after 3 months of conventional treatment on medium to high doses of inhaled corticosteroids (ICS) and long-acting beta 2-agonists (LABA); AND
- 5. Medication is being used as the add-on maintenance treatment to conventional therapies for asthma (i.e., ICS, LABA, etc.); AND
- 6. Medication is **NOT** used in conjunction with any other biologic therapy for asthma.
- 7. Dosage allowed/Quantity limit:

Adults and adolescents 12 years of age and older:





Pediatric patients age 6 to 11 years of age:

*No loading dose for this age group

If all the above requirements are met, the medication will be approved for 6 months.

For **reauthorization**:

1. Medication is **NOT** being used as monotherapy for asthma; AND





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