Dupixent (dupilumab)

NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This medical policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

DESCRIPTION

The intent of the policy is to provide coverage consistent with product labeling, FDA guidance, standards of medical practice, evidence-based drug information, and/or published guidelines. The indications below including FDA-approved indications and compendial uses are considered covered benefits provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications

1. Dupixent is indicated for the treatment of patients aged 6 months and older with moderate-to-severe atopic dermatitis 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.

2. Dupixent is indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 6 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.
   Limitation of use: Dupixent is not indicated for the relief of acute bronchospasm or status asthmaticus

3. Dupixent is indicated as an add-on maintenance treatment in patients 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

4. Dupixent is indicated for the treatment of adult and pediatric patients aged 1 year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE).

5. Dupixent is indicated for the treatment of adult patients with prurigo nodularis (PN).

6. Dupixent is indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype.
   Limitation of use: Dupixent is not indicated for the relief of acute bronchospasm

7. Dupixent is indicated for the treatment of adults and pediatric patients aged 12 years of age and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment.
   Limitation of use: Dupixent is not indicated for treatment of other forms of urticaria.

8. Treatment of adult patients with bullous pemphigoid (BP)

Compendial Uses

1. Immune checkpoint inhibitor-related toxicities

POLICY

Required Documentation

Submission of the following information is necessary to initiate the prior authorization review:

A. Atopic dermatitis

1. Initial requests:
   i. Member's chart notes or medical records showing affected area(s) and body surface area (where applicable).
   ii. Member's chart notes or medical record documentation and claims history of prerequisite therapies (see Criteria for Initial Approval A.2) including dosage, duration, and response to therapy. If prerequisite therapies are not advisable, documentation of why therapies are not advisable for the member.
2. Continuation requests: Documentation (e.g., chart notes) that the member has experienced a positive clinical response to therapy as evidenced by low disease activity or improvement in signs or symptoms of atopic dermatitis.

B. Asthma

1. For initial requests:
   i. Member's chart or medical record showing pretreatment blood eosinophil count (where applicable).
   ii. Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.
2. Continuation requests: Chart notes or medical record documentation supporting improvement in asthma control.

C. Chronic rhinosinusitis with nasal polyposis

1. For initial requests:
   i. Member's chart or medical record showing nasal endoscopy, anterior rhinoscopy details, or computed tomography (CT) (e.g., location, size), or Meltzer Clinical Score or endoscopic nasal polyp score (NPS) (where applicable).
   ii. Chart notes, medical record documentation, or claims history supporting previous medications tried, including drug, dose, frequency, and duration. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation of positive clinical response.

D. **Eosinophilic esophagitis**

1. For initial requests:

i. Member's chart or medical record showing endoscopic biopsy details including intraepithelial esophageal eosinophil count.
ii. Chart notes, medical record documentation, or claims history supporting previous medications tried. If therapy is not advisable, documentation of clinical reason to avoid therapy.

2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

E. Prurigo nodularis

1. For initial requests:
   i. Member's chart or medical record of symptoms (e.g., pruritus, nodular lesions).
   ii. Member's chart, medical record, or claims history of prerequisite therapies including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response.

F. Chronic obstructive pulmonary disease

1. For initial requests:
   i. Member's chart or medical record demonstrating inadequate control (e.g., COPD exacerbations and/or hospitalizations)
   ii. Chart notes, medical record documentation, or claims history supporting previous medications tried including drug, dose, frequency, and duration.
2. For continuation requests: Chart notes or medical record documentation supporting positive clinical response (reduction of exacerbations or improvement in FEV_1)

G. Chronic Spontaneous Urticaria (CSU):

1. Initial Requests: Member's chart notes or medical record documentation, or claims history supporting previous medications tried showing an inadequate treatment response to a second-generation H1 antihistamine
2. Continuation Requests: Chart notes or medical record documentation supporting response to therapy

H. Bullous Pemphigoid (BP)

1. For initial requests:
   i. Chart notes or medical record documentation demonstrating clinical features of bullous pemphigoid.
   ii. Chart notes, medical record documentation, or claims history of previous medications tried, including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation Requests: Chart notes or medical record documentation supporting positive clinical response

<u>Prescriber Specialties</u>

This medication must be prescribed by or in consultation with one of the following:

A. Atopic dermatitis: dermatologist or allergist/immunologist
B. Asthma: allergist/immunologist or pulmonologist
C. Chronic rhinosinusitis with nasal polyposis: allergist/immunologist or otolaryngologist
D. Chronic obstructive pulmonary disease: pulmonologist
E. Eosinophilic esophagitis: gastroenterologist or allergist/immunologist
F. Immune checkpoint inhibitor-related toxicity: dermatologist, hematologist or oncologist

G. Prurigo nodularis: dermatologist or allergist/immunologist
H. Chronic Spontaneous Urticaria (CSU): allergist/immunologist or dermatologist
I. Immune checkpoint inhibitor-related toxicity and bullous pemphigoid: dermatologist, hematologist, or oncologist

Criteria for Initial Approval

A. Moderate-to-severe atopic dermatitis

1) Authorization of **4 months** may be granted for members 6 months of age or older who have previously received a biologic (e.g., Adbry) or targeted synthetic drug (e.g., Cibinqo, Rinvoq) indicated for moderate-to-severe atopic dermatitis in the past year

2) Authorization of **4 months** may be granted for treatment of moderate-to-severe atopic dermatitis in members 6 months of age or older when all of the following criteria are met:
   A. Affected body surface area is greater than or equal to 10% OR crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
   B. Member meets one of the following:
      i. Member has had an inadequate treatment response to one of the following in the past 180 days:
         a. A medium potency to super-high potency topical corticosteroid (see Appendix A)
         b. A topical calcineurin inhibitor
      ii. The use of medium potency to super-high potency topical corticosteroids and topical calcineurin inhibitors are not advisable for the member (e.g., due to contraindications, prior intolerances, potency not appropriate for member's age)
   C. Member will not exceed the maximum FDA-approved dose for this indication.
   D. Member will not use Dupixent concomitantly with other biologics or JAK inhibitors indicated for atopic dermatitis.

B. Moderate-to-severe asthma

1. Authorization of **6 months** may be granted for members 6 years of age or older who have previously received a biologic drug (e.g., Fasenra, Nucala, Tezspire, Xolair, Cinqair) indicated for asthma.

2. Authorization of **6 months** may be granted for treatment of moderate-to-severe asthma in members 6 years of age or older when all of the following criteria are met:
   A. Member has uncontrolled asthma as demonstrated by experiencing at least one of the following within the past year:
      i. Two or more asthma exacerbations requiring oral or injectable corticosteroid treatment.
      ii. One or more asthma exacerbation resulting in hospitalization or emergency medical care visit.
      iii. Poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma).
   B. Member meets one of the following criteria:
      i. Member has a baseline blood eosinophil count of at least 150 cells per microliter and asthma is inadequately controlled despite treatment for at least 3 months with both of the following medications at maximally tolerated doses:
         a. Medium-to-high-dose inhaled corticosteroid
         b. Additional controller (i.e., long-acting beta-2 agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
      ii. Member has inadequate asthma control despite current treatment with all of the following medications at maximally tolerated doses*:
         a. High dose inhaled corticosteroid

b. Additional controller (i.e., long-acting beta-2 agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)
c. Oral glucocorticoids (at least 5 mg per day of prednisone/prednisolone or equivalent)

*Members should be receiving treatment with inhaled corticosteroid and additional controller for at least the previous 3 months, and oral glucocorticoids for most days during the previous 6 months (e.g., 50% of days, 3 steroid bursts in the previous 6 months).

C. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent.
D. Member will not use Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala, Tezspire, or Xolair).
E. Member will not exceed the maximum FDA-approved dose for this indication

C. Chronic rhinosinusitis with nasal polyposis (CRSwNP)

1. Authorization of **6 months** may be granted for members 12 years and older who have previously received a biologic drug (e.g., Nucala, Xolair, Tezspire) indicated for CRSwNP.

2. Authorization of **6 months** may be granted for treatment of CRSwNP in members 12 years of age or older when all of the following criteria are met:
   A. Member has bilateral nasal polyposis and chronic symptoms of sinusitis despite intranasal corticosteroid treatment for at least 2 months unless contraindicated or not tolerated; and
   B. The member has CRSwNP despite one of the following:
      i. Prior sino-nasal surgery; or
      ii. Prior treatment with systemic corticosteroids within the last two years was ineffective, unless contraindicated or not tolerated; and
   C. Member has one of the following:
      i. A bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril
      ii. Meltzer Clinical Score of 2 or higher in both nostrils
      iii. A total endoscopic nasal polyp score (NPS) of at least 5 with a minimum score of 2 for each nostril
   D. Member has symptoms of nasal blockage, congestion, or obstruction plus one additional symptom:
      i. Rhinorrhea (anterior/posterior); or
      ii. Reduction or loss of smell; or
      iii. Facial pain or pressure
   E. Member will continue to use a daily intranasal corticosteroid while being treated with Dupixent, unless contraindicated or not tolerated
   F. Member's dose will not exceed 300 mg every other week
   G. Member will not use Dupixent concomitantly with other biologics indicated for CRSwNP (e.g., Nucala, Xolair, Tezspire)

D. Eosinophilic esophagitis (EoE)

Authorization of **6 months** may be granted for treatment of EoE in members 1 year of age or older, weighing at least 15 kg, when all of the following criteria are met:

1. Member meets either of the following:
2. Member is 1 year of age to less than 11 years of age and has clinical manifestations of disease (e.g., vomiting, heartburn, abdominal pain, food refusal, failure to thrive).
3. Member is 11 years of age or older and has history of an average of at least 2 episodes of dysphagia (with intake of solids) per week
4. Diagnosis has been confirmed by esophageal biopsy as characterized by 15 or more intraepithelial esophageal eosinophils per high power field

5. Member has had an inadequate treatment response to either of the following:
    i. Proton pump inhibitor
    ii. Systemic corticosteroid or local therapies (e.g., budesonide, fluticasone [powder or suspension for inhalation] swallowed), unless contraindicated or not tolerated.
6. Member's dose will not exceed 300 mg every week

E. Prurigo nodularis (PN)

Authorization of **6 months** may be granted for treatment of prurigo nodularis in members 18 years of age or older when all of the following criteria are met:

1. Member has been diagnosed with PN for at least 6 weeks
2. Member has history or signs of repeated itch-scratch cycle (e.g., scratching, picking, or rubbing).
3. Member has 20 or more nodular lesions
4. Member meets one of the following:
    i. Member has had an inadequate response to one of the following:
        a. A medium to super-high potency topical corticosteroid (see Appendix A)
        b. A topical calcineurin inhibitor
        c. Phototherapy (e.g., UVB, PUVA)
        d. Pharmacologic treatment with methotrexate or cyclosporine
    ii. Member has had an intolerance or a clinical reason to avoid any of the following:
        a. Medium to super-high potency topical corticosteroid (see Appendix A) and topical calcineurin inhibitor
        b. Pharmacologic treatment with methotrexate and cyclosporine (see Appendix B)
5. Member's maintenance dose will not exceed 300 mg every other week

F. Chronic obstructive pulmonary disease (COPD)

Authorization of **6 months** may be granted for treatment of COPD in members 18 years of age or older when all of the following criteria are met:

1. Member has inadequately controlled COPD as demonstrated by experiencing at least one of the following within the past year:
    i. Two or more moderate exacerbations requiring corticosteroid or antibiotic treatment.
    ii. One or more severe exacerbation resulting in hospitalization or emergency medical care visit.
2. Diagnosis has been confirmed by spirometry showing forced expiratory volume in one second (FEV_1)/forced vital capacity (FVC) less than 0.7 post-bronchodilation.
3. Member demonstrates classic signs or symptoms of COPD (e.g., dyspnea, wheezing, chest tightness, fatigue, activity limitation, cough with or without sputum production, chronic bronchitis).
4. Member has a baseline blood eosinophil count of at least 300 cells per microliter
5. COPD remains uncontrolled after at least 3 months of maximally tolerated background controller therapy (LAMA-LABA and inhaled glucocorticoid, unless contraindicated)
6. Member will continue to use background controller therapy (LAMA-LABA and inhaled glucocorticoid, unless contraindicated) in combination with Dupixent.
7. Member will not exceed the maximum FDA-approved dose for this indication

G. Immune checkpoint inhibitor-related toxicity

1) Authorization of **6 months** may be granted for treatment of immune checkpoint inhibitor-related toxicity when member has immune-therapy related severe (G3) pruritis refractory to at least 1 month of treatment with gabapentinoids.

2) Authorization of **12 months** may be granted for treatment of immune checkpoint inhibitor-related toxicity when the requested medication will be used as additional therapy for moderate (G2) or severe (G3) bullous dermatitis.

H. Chronic Spontaneous Urticaria (CSU)

Authorization of **6 months** may be granted for treatment of chronic spontaneous urticaria when ALL of the following criteria are met:

1. Member is 12 years of age or older
2. Member remains symptomatic despite treatment with up-dosing (up to four times the recommended dose [see Appendix] in accordance with EAACI/GA^{2}LEN/EDF/WAO guidelines) of a second-generation H_1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine) for at least 2 weeks
3. Member has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis)
4. Member has experienced a spontaneous onset of wheals (hives), angioedema, or both, for at least 6 weeks
5. The requested dose is within the FDA labeled dose AND does not exceed 300 mg every 2 weeks

I. Bullous Pemphigoid

Authorization of 12 months may be granted for treatment of bullous pemphigoid in members 18 years of age or older when all of the following criteria are met:

1. Diagnosis has been confirmed by either of the following:
   i. Direct immunofluorescence (DIF) study
   ii. Immune serological test(s) (e.g., Indirect immunofluorescence microscopy [IIF], ELISA)
2. Member demonstrates characteristic clinical features of bullous pemphigoid (e.g., urticarial or eczematous or erythematous plaques, bullae, pruritus).
3. Member has moderate to severe disease.
4. Member meets either of the following:
   i. Member has had an inadequate treatment response with either of the following:
      a) A super-high potency topical corticosteroid (see Appendix A)
      b) An oral corticosteroid
   ii. The use of super-high potency topical corticosteroid or oral corticosteroid is not advisable for the member (e.g., contraindications, prior intolerances).

<u>Continuation of Therapy</u>

A. Moderate-to-severe atopic dermatitis

Authorization of **12 months** may be granted for members 6 months of age or older when all of the following criteria is met:

1. Member has achieved or maintained a positive clinical response with Dupixent therapy for moderate-to-severe atopic dermatitis as evidenced by low disease activity (i.e., clear or almost clear skin) or improvement in signs and symptoms of atopic dermatitis (e.g., redness, itching, oozing/crusting).
2. Member will not exceed the maximum FDA-approved dose for this indication
3. Member will not use Dupixent concomitantly with other biologics or JAK inhibitors indicated for atopic dermatitis.

B. Moderate-to-severe asthma

Authorization of **12 months** may be granted for continuation of treatment of moderate-to-severe asthma in members 6 years of age or older when all of the following criteria are met:

1. Member has achieved and maintained improved asthma control with Dupixent therapy as evidenced by at least one of the following:
    i. A reduction in the frequency and/or severity of symptoms and exacerbations
    ii. A reduction in the daily maintenance oral corticosteroid dose
2. Member will continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Dupixent.
3. Member will not use Dupixent concomitantly with other biologics indicated for asthma (e.g., Cinqair, Fasenra, Nucala, Tezspire or Xolair)
4. Member will not exceed the maximum FDA-approved dose for this indication

C. Chronic rhinosinusitis with nasal polyposis (CRSwNP)

Authorization of **12 months** may be granted for continuation of treatment of chronic rhinosinusitis with nasal polyposis in members 12 years of age or older when all of the following are met:

1. Member has achieved or maintained positive clinical response to Dupixent therapy as evidenced by improvement in signs and symptoms of CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)
2. Member will continue to use a daily intranasal corticosteroid while being treated with Dupixent, unless contraindicated or not tolerated
3. Member's dose will not exceed 300 mg every other week
4. Member will not use Dupixent concomitantly with other biologics indicated for CRSwNP (e.g., Nucala, Xolair)

D. Eosinophilic esophagitis

Authorization of **12 months** may be granted for continuation of treatment of eosinophilic esophagitis in members 1 year of age or older, weighing at least 15 kg, when all of the following are met:

1. Member has achieved or maintained a positive clinical response with Dupixent therapy as evidenced by improvement in signs and symptoms of eosinophilic esophagitis (e.g., dysphagia, heartburn, chest pain, emesis).
2. Member's dose will not exceed 300 mg every week

E. Prurigo nodularis

Authorization of **12 months** may be granted for members 18 years of age or older for continued treatment of prurigo nodularis when all of the following are met:

1. The member has achieved or maintained a positive clinical response with Dupixent therapy as evidenced by one of the following:
    i. Low disease activity (i.e., clear or almost clear skin).
    ii. Reduction in pruritis intensity and improvement in extent and severity of nodular lesions.
2. Member's dose will not exceed 300 mg every other week

F. Chronic obstructive pulmonary disease

Authorization of **12 months** may be granted for continuation of treatment of COPD in members 18 years of age or older when all of the following criteria are met:

1. Member has achieved and maintained improved COPD control with Dupixent therapy as evidenced by at least one of the following:
    iii. A reduction in the frequency and/or severity of exacerbations
    iv. A improvement in lung function (FEV_1)

2. Member will continue to use maintenance COPD treatments (LAMA-LABA and inhaled glucocorticoid, unless contraindicated) in combination with Dupixent.
3. Member will not exceed the maximum FDA-approved dose for this indication

G. Immune checkpoint inhibitor-related toxicities

1. Authorization of 12 months may be granted for all members (including new members) requesting authorization for continuation of therapy for severe (G3) pruritis must meet all initial authorization criteria.
2. Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for moderate (G2) or severe (G3) bullous dermatitis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition.

H. Chronic Spontaneous Urticaria

Authorization of **12 months** may be granted for continuation of treatment of chronic spontaneous urticaria when ALL of the following criteria are met:

1. Member is 12 years of age or older
2. Member has experienced a positive response (e.g., improved symptoms, decrease in weekly urticaria activity score [UAS7]) since initiation of therapy
3. The requested dose is within the FDA labeled dose AND does not exceed 300 mg every 2 weeks

I. Bullous Pemphigoid

Authorization of **12 months** may be granted for continuation of treatment of bullous pemphigoid when either of the following is met:

1. Low disease activity
2. Reduction in pruritic intensity and improvement in extent and severity of lesions

*Note: If the member is a current smoker or vaper, they should be counseled on the harmful effects of smoking and vaping on pulmonary conditions and available smoking and vaping cessation options.

Other

Dupixent is considered **not medically necessary** for members who do not meet the criteria set forth above.

Member cannot use Dupixent concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Members currently receiving the requested medication as samples or via the manufacturer's patient assistance program will be required to meet the criteria for initial approval. This ensures that members are treated equally regardless of their provider's ability to access medication samples.

Dosing and Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Quantity Limits

<table>
<tr><th>Medication</th><th>Standard Limit</th><th>FDA-recommended dosing</th></tr>
<tr><td rowspan="2">Dupixent 100 mg/ 0.67 mL pre-filled syringe

Dupixent 200 mg/ 1.14 mL pre-filled syringe or pen-injector</td><td>Maintenance:
2 syringes per 28 days</td><td rowspan="3">Atopic dermatitis
• Adults and adolescents weighing ≥ 60 kg: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week.
<u>Age 6 months to 5 years:</u>
• Body weight 5 to < 15 kg: 200 mg every four weeks
• Body weight 15 to < 30 kg: 300 mg every four weeks
<u>Age 6 to 17 years:</u>
• Body weight 15 to < 30 kg: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every 4 weeks.
• Body weight 30 to < 60 kg: Initial dose of 400 mg (two 200 mg injections), followed by 200 mg every other week
Asthma (patients 12 years of age and older)
• Initial dose of 400 mg (two 200 mg injections), followed by 200 mg every other week, or
• Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week
• Patients with oral corticosteroid-dependent asthma, or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated: initial dose of 600 mg followed by 300 mg every other week
Asthma (patients 6-11 years of age)
• Body weight 15 to less than 30 kg: 100 mg every other week OR 300 mg every 4 weeks
• Body weight ≥ 30 kg: 200 mg every other week
Chronic rhinosinusitis with nasal polyposis (CRSwNP) and chronic obstructive pulmonary disease (COPD)
• 300 mg every other week
Chronic Spontaneous Urticaria
• Adults and adolescents (age 12-17) weighing ≥ 60 kg: Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every 2 weeks
• Adolescents (age 12-17) weighing 30 to <60 kg: initial dose of 400 mg (two 200 mg injections), followed by 200 mg every 2 weeks
Eosinophilic esophagitis
• 15 to less than 30 kg: 200 mg every 2 weeks
• 30 to less than 40 kg: 300 mg every 2 weeks
• 40 kg or more: 300 mg every week
Prurigo nodularis and bullous pemphigoid
• Initial dose of 600 mg (two 300 mg injections), followed by 300 mg every other week</td></tr>
<tr><td>Initiation of therapy*:
4 syringes/pens per first 28 days

Maintenance:
2 syringes/pens per 28 days</td></tr>
<tr><td>Dupixent 300 mg/ 2 mL pre-filled syringe or pen-injector</td><td>Initiation of therapy*:
4 syringes/pens per first 28 days

Maintenance:
2 syringes/pens per 28 days

Maintenance (EoE):
4 syringes/pens per 28 days</td></tr>
</table>

*Loading doses do not apply to patients 6 months to 5 years of age with atopic dermatitis, patients 6-11 years of age with asthma, eosinophilic esophagitis, and chronic rhinosinusitis with nasal polyposis.

Appendix A: Relative potency of select topical corticosteroid products

Relative potency of select topical corticosteroid products			
Potency	**Drug**	**Dosage form**	**Strength**
I. Super-high potency (group 1)	Augmented betamethasone dipropionate	Ointment, Lotion, Gel	0.05%
	Clobetasol propionate	Cream, Gel, Ointment, Solution, Cream (emollient), Lotion, Shampoo, Foam, Spray	0.05%
	Fluocinonide	Cream	0.1%
	Flurandrenolide	Tape	4 mcg/cm^2
	Halobetasol propionate	Cream, Lotion, Ointment, Foam	0.05%
II. High potency (group 2)	Amcinonide	Ointment	0.1%
	Augmented betamethasone dipropionate	Cream	0.05%
	Betamethasone dipropionate	Ointment	0.05%
	Clobetasol propionate	Cream	0.025%
	Desoximetasone	Cream, Ointment, Spray	0.25%
		Gel	0.05%
	Diflorasone diacetate	Ointment, Cream (emollient)	0.05%
	Fluocinonide	Cream, Ointment, Gel, Solution	0.05%
	Halcinonide	Cream, Ointment	0.1%
	Halobetasol propionate	Lotion	0.01%
III. High potency (group 3)	Amcinonide	Cream, Lotion	0.1%
	Betamethasone dipropionate	Cream, hydrophilic emollient	0.05%
	Betamethasone valerate	Ointment	0.1%
		Foam	0.12%
	Desoximetasone	Cream, Ointment	0.05%
	Diflorasone diacetate	Cream	0.05%
	Fluocinonide	Cream, aqueous emollient	0.05%
	Fluticasone propionate	Ointment	0.005%
	Mometasone furoate	Ointment	0.1%
	Triamcinolone acetonide	Cream, Ointment	0.5%
IV. Medium potency (group 4)	Betamethasone dipropionate	Spray	0.05%
	Clocortolone pivalate	Cream	0.1%
	Fluocinolone acetonide	Ointment	0.025%
	Flurandrenolide	Ointment	0.05%
	Hydrocortisone valerate	Ointment	0.2%
	Mometasone furoate	Cream, Lotion, Solution	0.1%
	Triamcinolone acetonide	Cream	0.1%
		Ointment	0.05% and 0.1%
		Aerosol Spray	0.2 mg per 2-second spray
V. Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	0.05%
	Betamethasone valerate	Cream	0.1%
	Desonide	Ointment, Gel	0.05%

Relative potency of select topical corticosteroid products			
Potency	**Drug**	**Dosage form**	**Strength**
	Fluocinolone acetonide	Cream	0.025%
	Flurandrenolide	Cream, Lotion	0.05%
	Fluticasone propionate	Cream, Lotion	0.05%
	Hydrocortisone butyrate	Cream, Lotion, Ointment, Solution	0.1%
	Hydrocortisone probutate	Cream	0.1%
	Hydrocortisone valerate	Cream	0.2%
	Prednicarbate	Cream (emollient), Ointment	0.1%
	Triamcinolone acetonide	Lotion	0.1%
		Ointment	0.025%
VI. Low potency (group 6)	Alclometasone dipropionate	Cream, Ointment	0.05%
	Betamethasone valerate	Lotion	0.1%
	Desonide	Cream, Lotion, Foam	0.05%
	Fluocinolone acetonide	Cream, Solution, Shampoo, Oil	0.01%
	Triamcinolone acetonide	Cream, Lotion	0.025%
VII. Least potent (group 7)	Hydrocortisone (base, greater than or equal to 2%)	Cream, Ointment, Solution	2.5%
		Lotion	2%
	Hydrocortisone (base, less than 2%)	Cream, Ointment, Gel, Lotion, Spray, Solution	1%
		Cream, Ointment	0.5%
	Hydrocortisone acetate	Cream	2.5%
		Lotion	2%
		Cream	1%

Appendix B: Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate or Cyclosporine

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
2. Drug interaction
3. Risk of treatment-related toxicity
4. Pregnancy or currently planning pregnancy
5. Breastfeeding
6. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
7. Hypersensitivity
8. History of intolerance or adverse event

PROCEDURES AND BILLING CODES

To report provider services, use appropriate CPT* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.

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