New Hampshire Medicaid Fee-for-Service Program Dupixent (dupilumab) Criteria

Approval Date: November 21, 2024

Indications

- Add-on maintenance treatment in patients 6 years of age and older with moderate to severe asthma with an eosinophilic phenotype or with oral corticosteroid-dependent asthma
- Treatment of moderate-to-severe atopic dermatitis in patients 6 months of age and older whose disease is not adequately controlled with topical prescription therapies or when those therapies are inadvisable
- Add-on maintenance treatment for adults and pediatric patients 12 years of age and older with inadequately controlled chronic rhinosinusitis with nasal polyposis
- Treatment of eosinophilic esophagitis in adults and pediatric patients 1 year of age and older (weighing at least 15 kg)
- Treatment of prurigo nodularis in adults
- Add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype
- Treatment of chronic spontaneous urticaria (CSU) in adults and pediatric patients 12 years of age and older who are symptomatic despite H1 antihistamine treatment
- Treatment of bullous pemphigoid in adults

Medications

Brand Names	Generic Names	Dosage
Dupixent	dupilumab	300 mg/2 mL, 200 mg/1.14 mL single-dose prefilled pen 300 mg/2 mL, 200 mg/1.14 mL, 100 mg/0.67 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 ≥ 6 years of age; **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. Baseline blood eosinophils ≥ 150 cells/mcL and 1 exacerbation in the last year **or** patient requires oral corticosteroids to manage asthma.

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. Failure to be compliant with current regimen as evidenced by review of claims history; **OR**
4. 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, immunologist, or allergist (or one has been consulted); **AND**
2. Patient is ≥ 6 months of age; **AND**
3. Diagnosis of moderate to severe atopic dermatitis; **AND**
4. Patient has a defined failure, 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**
5. Patient has a defined failure, contraindication, or intolerance to a trial of pimecrolimus **or** a trial of tacrolimus **or** a trial of Eucrisa (crisaborole). A trial constitutes at least one month of therapy; **AND**

Length of Approval: Six months

Renewal: Twelve 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 ≥ 12 years of age; **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 two 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.

Criteria for Approval for Eosinophilic Esophagitis

1. Prescriber is a gastroenterologist, immunologist, or allergist (or one has been consulted)**; AND**
2. Patient is ≥ 1 year of age and weighing ≥ 15 kg; **AND**
3. Diagnosis of eosinophilic esophagitis**.**

Length of Authorization

Length of Approval: Six months

Renewal: Twelve months

Criteria for Denial

Failure to meet criteria for approval.

Criteria for Renewal

Clinical improvement was seen.

Criteria for Approval for Prurigo Nodularis

1. Prescriber is a dermatologist, immunologist, or allergist (or one has been consulted); **AND**
2. Patient is ≥ 18 years of age; **AND**
3. Diagnosis of prurigo nodularis.

Length of Authorization

Length of Approval: Six months

Renewal: Twelve months

Criteria for Denial

Failure to meet criteria for approval.

Criteria for Renewal

Clinical improvement was seen.

Criteria for Approval for COPD

1. Prescriber is a pulmonologist (or one has been consulted); **AND**
2. Patient is ≥ 18 years of age; **AND**
3. Diagnosis of COPD with lung function classified by GOLD Grade 2 or 3 (FEV-1% predicted between 30–70%); **AND**
4. Blood eosinophil count ≥ 300 cells/μL within the past 12 months; **AND**
5. Patient is receiving maximal inhaled therapy for a minimum of 3 months (LAMA/LABA/ICS or LAMA/LABA if ICS is contraindicated); **AND**

6. Patient is inadequately controlled, defined by exacerbation history (2 moderate – oral corticosteroid or antibiotic required or 1 severe – hospitalization or ER visit).

Length of Authorization

Length of Approval: Six months

Renewal: Twelve months

Criteria for Denial

Failure to meet criteria for approval.

Criteria for Renewal

Clinical improvement was seen.

Criteria for Approval for Chronic Spontaneous Urticaria

1. Prescriber is an allergist, immunologist, or dermatologist (or one of these specialists has been consulted); **AND**
2. Patient is ≥ 18 years of age; **AND**
3. Patient has had an inadequate response to first or second generation H1-antihistamine.

Length of Authorization

Length of Approval: Six months

Renewal: Twelve months

Criteria for Denial

Failure to meet criteria for approval.

Criteria for Renewal

Clinical improvement was seen.

Criteria for Approval for Bullous Pemphigoid

1. Prescriber is a dermatologist, immunologist, or allergist (or one has been consulted); **AND**
2. Patient is ≥ 18 years of age; **AND**

3. Diagnosis of bullous pemphigoid.

Length of Authorization

Length of Approval: Six months

Renewal: Twelve months

Criteria for Denial

Failure to meet criteria for approval.

Criteria for Renewal

Clinical improvement was seen.

References

Available upon request.

Revision History

Reviewed By	Reason for Review	Date Approved
DUR Board	New	06/30/2020
Commissioner Designee	Approval	08/7/2020
DUR Board	Revision	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	12/02/2021
Commissioner Designee	Approval	01/14/2022
DUR Board	Revision	12/13/2022
Commissioner Designee	Approval	01/26/2023
DUR Board	Revision	06/19/2023
Commissioner Designee	Approval	06/29/2023
DUR Board	Revision	10/15/2024
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DUR Board	Revision	09/23/2025
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