MEDICAL MUTUAL®

Drug Policy

Policy:	**201704**	**Initial Effective Date: 05/21/2017**
Code(s):	**HCPCS J3490, J3590**	**Annual Review Date: 04/19/2018**
SUBJECT:	**Dupixent® (dupilumab)**	**Last Revised Date: 11/15/2018**

Prior approval is required for some or all procedure codes listed in this Corporate Drug Policy.

Overview

Dupixent is indicated for the treatment of adult patients with moderate to severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.[1] Dupixent is also indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma. Dupixent is not indicated for the relief of acute bronchospasm or status asthmaticus.

Dupixent is a human monoclonal antibody that binds to the interleukin-4 receptor alpha (IL-4Rα) subunit shared by the interleukin (IL)-4 and IL-13 receptor complexes, thereby inhibiting IL-4 and IL-13 signaling. This inhibition limits IL-4 and IL-13 cytokine-induced responses, including the release of proinflammatory cytokines, chemokines, and immunoglobulin (Ig)E involved in type 2 inflammation. For the treatment of atopic dermatitis, Dupixent is dosed as a one-time loading dose of 600 mg (administered as two 300 mg subcutaneous [SC] injections), followed by 300 mg SC once every other week (QOW). For the treatment of adults and adolescents with asthma, Dupixent is dosed as a one-time loading dose of 400 mg (administered as two 200 mg SC injections) followed by 200 mg SC QOW or as a one-time loading dose of 600 mg (administered as two 300 mg SC injections) followed by 300 mg SC QOW. For patients with oral corticosteroid-dependent asthma, or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated, start with an initial dose of 600 mg SC followed by 300 mg SC QOW. Dupixent may be administered by the patient or caregiver following appropriate training.

Clinical Efficacy

Asthma

The efficacy of Dupixent for the treatment of asthma was established in three randomized, double-blind, placebo-controlled, multicenter, pivotal studies in patients with persistent asthma.[11,12,13] Study 1 (n = 776) [published] was a Phase IIb, 24-week study that included adult patients with uncontrolled asthma despite therapy with a medium-to-high dose inhaled corticosteroid (ICS) and up to two additional controller medications.[13] The annualized exacerbation rate was reduced by -70.0% with Dupixent 200 mg SC once every 2 weeks (Q2W) and -70.5% with Dupixent 300 mg SC Q2W compared with placebo ($P < 0.05$ for each comparison). The relative risk reduction was greater in the subgroup of patients with a baseline blood eosinophil count ≥ 300 cells/microliter (80.7% reduction with Dupixent 300 mg SC Q2W vs. placebo). Significant improvements in the forced expiratory volume in 1 second (FEV_1) were also observed with both Q2W doses of Dupixent vs. placebo. The second study, LIBERTY ASTHMA QUEST (n = 1,902) [published], was a

Phase III study that included patients ≥ 12 years of age who had moderate-to-severe asthma uncontrolled despite treatment with a medium- to high-dose inhaled corticosteroid (ICS) and up to two additional controller medications.[11] Over the 52-week treatment period, Dupixent 200 mg SC Q2W and 300 mg SC Q2W reduced the adjusted annualized rate of severe asthma exacerbations vs. placebo by -47.7% and -46.0%, respectively (P < 0.001 for both comparisons). At Week 12, FEV_1 was increased by 0.14 L with Dupixent 200 mg vs. placebo and 0.13 L with Dupixent 300 mg vs. placebo. Larger improvements in both asthma exacerbations and FEV_1 values were observed in patients with a baseline blood eosinophil count ≥ 300 cells/microliter as well as in patients with an elevated baseline fraction of exhaled nitric oxide (FE_{NO}) ≥ 25 parts per billion (ppb). A second Phase III study, LIBERTY ASTHMA VENTURE (n = 210) [published], included patients ≥ 12 years of age who had severe asthma that required regular treatment with systemic corticosteroids despite treatment with a high-dose ICS and up to two additional controller medications.[12] From baseline to Week 24, the oral corticosteroid dose was reduced by -70.1% with Dupixent 300 mg SC Q2W compared with -41.9% with placebo (P < 0.001), while maintaining asthma control. In total, 80% of patients receiving Dupixent achieved at least a 50% corticosteroid dose reduction vs. 50% of patients assigned to placebo (P < 0.001). Dupixent was associated with a greater oral corticosteroid dose reduction regardless of baseline blood eosinoiphil count; however, the magnitude of the dose reduction was larger in patients with blood eosinophils > 300 cells/microliter. In addition to reducing oral corticosteroid use, Dupixent reduced the rate of severe asthma exacerbations by -59% compared with placebo.

Atopic Dermatitis (AD)

The efficacy of Dupixent for the treatment of AD was established in three Phase III, randomized, double-blind, placebo-controlled, multicenter, pivotal studies in adults (≥ 18 years of age) with moderate to severe AD inadequately controlled by standard topical therapies (e.g., emollients, topical corticosteroids, topical calcineurin inhibitors).[1-3] SOLO 1 and SOLO 2 evaluated Dupixent as monotherapy; CHRONOS evaluated Dupixent in combination with topical corticosteroid therapy. In each study, the primary efficacy endpoint was a score of 0 (clear) or 1 (almost clear) on the Investigator's Global Assessment (IGA) and a reduction of ≥ 2 points from baseline to Week 16. In SOLO 1 (n = 671) [published] and SOLO 2 (n = 708) [published], Dupixent was more effective in achieving the primary endpoint at Week 16 compared with placebo.[2] In SOLO 1, the primary endpoint was achieved in 38% of patients treated with Dupixent 300 mg QOW vs. 10% of patients treated with placebo (P < 0.001). In SOLO 2, the primary endpoint was achieved in 36% of patients treated with Dupixent 300 mg QOW vs. 8% of patients treated with placebo (P < 0.001). CHRONOS (published) [n = 740], also found Dupixent to be more effective in achieving the primary endpoint at Week 16 and at Week 52 compared with placebo.[3] At Week 16, more patients who received Dupixent QOW (with topical corticosteroids) vs. placebo (with topical corticosteroids) achieved an IGA 0/1 (39% vs 12%, respectively; p<0·0001) and an Eczema Area and Severity Index 75% improvement from baseline (EASI-75) [69% vs. 23%, respectively; p<0·0001). Week 52 results were similar.

Guidelines

Asthma

The 2018 Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention does not address Dupixent.[9] GINA proposes a step-wise approach to asthma treatment.[2] For patients with persistent symptoms or exacerbations despite therapy with a medium- to high-dose ICS/long-acting $beta_2$-agonist (LABA) combination with or without an additional controller, the GINA document recommends referral of the patient to a specialist who may consider additional treatments. Options for add-on therapy in patients with severe the severe eosinophilic phenotype of asthma include the anti-IL-5 agents. Again, Dupixent is not yet addressed in these recommendations.

Atopic Dermatitis (AD)

The American Academy Dermatology (AAD) guidelines of care for the management of AD (2014) and the Joint Task Force AD practice parameter (from the American Academy of Allergy, Asthma, and Immunology [AAAAI], the American College of Allergy, Asthma, and Immunology [ACAAI], and the Joint Council of Allergy, Asthma, and Immunology [JCAAI]) [2012] make similar recommendations for AD therapy.[4-6] The majority of patients with AD can achieve disease control with non-pharmacologic interventions (e.g., emollients), standard topical anti-inflammatory therapies (e.g., topical corticosteroids, topical calcineurin inhibitors), and elimination of exacerbating factors (e.g., allergens, irritants, and emotional stress). A patient who does not respond to first-line therapy should be referred to a provider who specializes in the treatment of AD. If topical regimens and/or phototherapy continue to inadequately control the signs and symptoms of AD, systemic immunomodulatory therapies are indicated, particularly if the patient's disease has significant negative physical, psychological, or social effects. Several different systemic agents have been used in the treatment of AD. Data comparing the available systemic therapies for AD are limited and the guidelines have not been updated to include Dupixent.

POLICY STATEMENT

This policy involves the use of Dupixent. Prior authorization is recommended for pharmacy and medical benefit coverage of Dupixent. Approval is recommended for those who meet the conditions of coverage in the **Criteria, Dosing, Initial/Extended Approval, Duration of Therapy**, and **Labs/Diagnostics** for the diagnosis provided. **Waste Management** applies for all covered conditions that are administered by a healthcare professional. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria and Waste Management section. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Dupixent as well as the monitoring required for AEs and long-term efficacy, initial approval requires Dupixent be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below. The Site of Care Medical Necessity Criteria applies to initial therapy and reauthorizations under the medical benefit.*

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Dupixent is recommended in those who meet the following criteria:

FDA-Approved Indications

1. **Asthma in Patients with Moderate to Severe Disease.** Approve Dupixent for the duration noted if the patient meets one of the following conditions (A or B):
   - **A)** Initial Therapy: Approve Dupixent for 6 months if the patient meets the following criteria (i, ii, iii, iv, v and vi):
     - **i.** Patient is ≥ 12 of age; AND
     - **ii.** Dupixent is prescribed by or in consultation with an allergist, immunologist, or pulmonologist; AND

iii. Patient meets ONE of the following criteria (a or b):
- **a)** Patient has a blood eosinophil level of ≥ 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy (e.g., Dupixent, Nucala, Cinqair, Fasenra); OR
- **b)** Patient has oral (systemic) corticosteroid-dependent asthma (e.g., has received ≥ 5 mg oral prednisone or equivalent per day for ≥ 6 months), per the prescribing physician; AND

iv. Patient has received at least 3 consecutive months of combination therapy with BOTH of the following (a and b):
- **a)** An inhaled corticosteroid (ICS) [e.g. Flovent Diskus/HFA, ArmonAir RespiClick, Arnuity Ellipta, Asmanex Twisthaler/HFA, Aersopan, Alvesco, Pulmicort Flexhaler, budesonide suspension for inhalation {Pulmicort Respules, generics}, Qvar/Qvar RediHaler]; AND
- **b)** At least ONE of the following (1, 2, 3 or 4):
  - **(1)** Inhaled long-acting beta-agonist (LABA) [e.g., Serevent Diskus]; OR
    NOTE: Use of a combination inhaler containing both an ICS and a LABA would fulfil the requirement for both criteria a and b (e.g., Advair Diskus/HFA, AirDuo RespiClick, Symbicort, Breo Ellipta, and Dulera).
  - **(2)** Inhaled long-acting muscarinic antagonist (LAMA) [e.g., Spiriva Respimat]; OR
  - **(3)** Leukotriene receptor antagonist (LTRA) [e.g. montelukast tablets/granules {Singulair, generics}, zafirlukast tablets {Accolate, generics}]; OR
  - **(4)** Theophylline (Theo-24, TheoChron ER, generics); AND

v. Patient's asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy as defined by ONE of the following (a, b, c, d or e):
- **a)** The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year; OR
- **b)** The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year; OR
- **c)** Patient has a forced expiratory volume in 1 second (FEV_1) < 80% predicted; OR
- **d)** Patient has an FEV_1/forced vital capacity (FVC) < 0.80; OR
- **e)** The patient's asthma worsens upon tapering of oral corticosteroid therapy; AND

vi. Site of care medical necessity is met*..

B) Patients Continuing Dupixent Therapy: Approve Dupixent for 1 year if the patient meets the following criteria (i, ii, iii and iv):

i. The patient has already received at least 6 months of therapy with Dupixent (Note: Patients who have received < 6 months of therapy or those who are restarting therapy with Dupixent should be considered under criterion 1A [Asthma in Patients with Moderate to Severe Disease, Initial Therapy]); AND

ii. Patient continues to receive therapy with one inhaled corticosteroid (ICS) or one ICS-containing combination inhaler (e.g., Flovent Diskus/HFA, ArmonAir RespiClick, Arnuity Ellipta, Asmanex Twisthaler/HFA, Aersopan, Alvesco, Pulmicort Flexhaler, budesonide suspension for inhalation [Pulmicort Respules, generics], Qvar/Qvar RediHaler, Advair Diskus/HFA, AirDuo RespiClick, Symbicort, Breo Ellipta, and Dulera); AND

iii. The patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department (ED)/urgent care, or physician visits due to asthma; decreased requirement for oral corticosteroid therapy; AND

iv. Site of care medical necessity is met.*

Dupixent is indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.[1] The pivotal studies of Dupixent included patients ≥ 12 years of age who had moderate to severe asthma that was uncontrolled despite treatment with a medium- to high-dose ICS and up to two additional controller medications.[11,13] In these studies, therapy with Dupixent resulted in improvements in asthma exacerbation rates and lung function parameters (i.e, FEV_1) compared with placebo. Higher baseline eosinophil levels were correlated with larger asthma exacerbation reductions and greater increases in lung function parameters than were observed in the overall patient population. In patients with baseline blood eosinophil levels < 150 cells/microliter, the magnitude of the reductions in asthma exacerbations observed with Dupixent vs. placebo were non-significant. An additional pivotal trial included patients with severe asthma who were oral corticosteroid dependent.[12] Patients who received Dupixent were able to significantly reduce their oral corticosteroid doses compared with placebo. Dupixent was associated with a greater oral corticosteroid dose reduction regardless of baseline blood eosinoiphil count. Current recommendations from the Global Initiative for Asthma (GINA) [2018] confirm that ICSs remain the mainstay of therapy even in the setting of difficult-to-treat, severe asthma.[9] The GINA document also defines asthma severity. Moderate asthma is defined as asthma that is well controlled with a low-dose ICS/LABA combination; patients well controlled on a medium- to high-dose ICS and a low-dose ICS + an LTRA or theophylline would also meet this definition. Severe asthma is defined as asthma that requires a high-dose ICS/LABA to prevent it from becoming "uncontrolled" or asthma that remains "uncontrolled" despite this treatment. Patients who require therapy with a medium- to high-dose ICS/LABA + tiotropium, an LTRA, or theophylline would also meet this definition. The 2014 ERS/ATS guidelines on severe asthma define severe asthma similarly.[14] These guidelines define uncontrolled asthma as asthma that meets one of the following four criteria: poor symptom control; frequent severe exacerbations (two or more requiring systemic corticosteroids per year); serious exacerbations (one hospitalization in the previous year); or airflow limitation (FEV_1 < 80% of predicted in the setting of reduced FEV_1/FVC). Additionally, patients may also have severe asthma if their asthma worsens upon tapering of corticosteroids (high-dose ICSs or systemic corticosteroids). In the opinion of expert physicians reviewing the data we have adopted the ERS/ATS criteria for uncontrolled asthma.

Recommended dosage Dupilumab:

Asthma, moderate to severe: SubQ:
Initial: 400 mg (given as two 200 mg injections) **or** 600 mg (given as two 300 mg injections)
Maintenance: 200 mg (following 400 mg initial dose) **or** 300 mg (following 600 mg initial dose) once every other week

Asthma, oral corticosteroid dependent or with comorbid moderate to severe atopic dermatitis: SubQ:
Initial: 600 mg (given as two 300 mg injections)
Maintenance: 300 mg once every other week

Duration of Therapy. Indefinite or until toxicity occurs.

2. Atopic Dermatitis, moderate to severe.

A) Initial Therapy. Approve for 16 weeks if the patient meets the following criteria (i, ii, iii, iv, and v):

- **i.** Patient is ≥ 18 of age; AND
- **ii.** Dupixent is prescribed by or in consultation with an allergist, immunologist, or dermatologist; AND
- **iii.** Patient meets ONE of the following (a or b)
  - **a)** Patient has atopic dermatitis involvement estimated to be ≥ 10% of the body surface area (BSA) according to the prescribing physician; AND meets all of the following criteria: (1, 2 and 3)
    - **(1)** Patient has used at least one medium-, medium-high, high-, and/or super-high-potency prescription topical corticosteroid; AND
    - **(2)** This topical corticosteroid was applied daily for at least 28 consecutive days; AND
    - **(3)** Inadequate efficacy was demonstrated with this topical corticosteroid therapy, according to the prescribing physician; OR
  - **b)** Patient has atopic dermatitis involvement estimated to be < 10% of the BSA according to the prescribing physician and meets ALL of the following criteria ([1], [2], [3], and [4]):
    - **(1)** Patient has atopic dermatitis affecting ONLY the following areas: face, eyes/eyelids, skin folds, and/or genitalia; AND
    - **(2)** Patient has tried tacrolimus ointment (Protopic®, generics); AND
    - **(3)** Tacrolimus ointment (Protopic, generics) was applied daily for at least 28 consecutive days; AND
    - **(4)** Inadequate efficacy was demonstrated with tacrolimus ointment (Protopic, generics), according to the prescribing physician.
- **iv.** Patient meets all of the following (a and b):
  - **a)** In the past 6 months, the patient has tried at least one of the following systemic agents: oral corticosteroid, intramuscular corticosteroid, oral cyclosporine, oral azathioprine, oral methotrexate, or oral mycophenolate mofetil; AND
  - **b)** Inadequate efficacy was demonstrated with systemic therapy, according to the prescribing physician.
- **v.** Site of care medical necessity is met*.

B) Patients Continuing Dupixent Therapy. Approve for 1 year if the patient meets the following criteria (i, ii, iii, iv and v.):

- **i.** Patient is ≥ 18 years of age; AND
- **ii.** The patient has already received at least 16 weeks of therapy with Dupixent (Note: Patients who have received < 16 weeks of therapy or those who are restarting therapy with Dupixent should be considered under criterion 1 [Atopic Dermatitis, moderate to severe, Initial Therapy]); AND
- **iii.** Dupixent is prescribed by or in consultation with an allergist, immunologist, or dermatologist; AND
- **iv.** The patient has responded to Dupixent therapy as determined by the prescribing physician (e.g., marked improvements erythema, induration/papulation/edema, excoriations, and lichenification; reduced pruritus; decreased requirement for other topical or systemic therapies; reduced body surface area (BSA) affected with atopic dermatitis; or other responses observed); AND
- **v.** Site of care medical necessity is met*.

Dupixent is indicated for the treatment of adult patients with moderate to severe atopic dermatitis (AD) whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.[1] The three pivotal Dupixent studies, SOLO 1, SOLO 2, and CHRONOS, enrolled patients ≥ 18 years of age who had a diagnosis of moderate to severe chronic AD present for ≥ 3 years prior to screening.[1-3] Patients' also had a recent (within 6 months) history of an inadequate response to a sufficient course of topical therapy for AD, which included topical corticosteroids and/or topical calcineurin inhibitors (e.g., Protopic). In the SOLO studies, patients were also required to have AD involvement of ≥ 10% of their body surface area (BSA). In the pivotal studies the primary endpoint as well as key secondary endpoints were measured following 16 weeks of therapy. Dupixent demonstrated efficacy at this time point as well as earlier on in the course of therapy. Current AD guidelines from the American Academy Dermatology (AAD) [2014] and a Joint Task Force AD practice parameter (2012) recommend initial therapy with non-pharmacologic interventions (e.g., moisturizers/emollients), followed by standard topical anti-inflammatory therapies such as topical corticosteroids and topical calcineurin inhibitors (e.g., Protopic).[4-6] A patient who does not respond to these first-line therapies should be referred to a provider who specializes in the treatment of AD. If topical regimens and/or phototherapy continue to inadequately control the signs and symptoms of AD, systemic immunomodulatory therapies (e.g., systemic corticosteroids, cyclosporine, azathioprine, methotrexate, mycophenolate mofetil) are indicated.[5] When using any systemic therapy, the guidelines recommend that adjunctive therapies should be continued to allow for the lowest possible dose of the immunomodulatory agent. In the opinion of expert physicians reviewing the data we have adopted this criteria.

Recommended dosage Dupilumab:

The recommended dose is an initial dose of 600 mg (two 300 mg injections in different injection sites), followed by 300 mg given every other week.

Duration of Therapy is indefinite or until toxicity occurs.

Waste Management for All Indications.
Injection: 300 mg/2 mL solution in a single-dose pre-filled syringe with needle shield

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CONDITIONS NOT RECOMMENDED FOR APPROVAL

Dupixent has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. Rationale for non-coverage for these specific conditions is provided below. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval.)

1. **Concurrent use of Dupixent with Xolair® (omalizumab injection for subcutaneous use).** Xolair is a recombinant humanized immunoglobulin G (IgG)1κ monoclonal antibody indicated for use in adults and adolescents (aged ≥ 6

years) with moderate to severe persistent asthma and who have a positive skin test or *in vitro* reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with ICSs.[11] The efficacy and safety of Dupixent used in combination with Xolair have not been established.

2. **Concurrent use of Dupixent with another Interleukin (IL) Antagonist Monoclonal Antibody.** The efficacy and safety of Dupixent in combination with any other IL antagonist have not been established.

3. **Eosinophilic Esophagitis**. A Phase II study is underway evaluating Dupixent for the treatment of eosinophilic esophagitis.[9] Results are not yet available. The efficacy and safety of Dupixent for the treatment of eosinophilic esophagitis have not been established.

4. **Nasal Polyps.** Dupixent has also been studied for the treatment of chronic sinusitis with nasal polyposis.[9-10] One published, Phase II randomized, double-blind, placebo-controlled, multicenter study (n = 60) found a significant improvement in the nasal polyp score at Week 16 with Dupixent 300 mg QW vs. placebo in adult patients whose chronic sinusitis and nasal polyposis was refractory to intranasal corticosteroid therapy alone. Both placebo and active therapy were used in combination with mometasone nasal spray. Further research is warranted to determine if Dupixent has a place in therapy in the treatment of nasal polyps.

5. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

References

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OTHER REFERENCES USED

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FOR MEDICAL BENEFIT COVERAGE REQUESTS:

***MMO Site of Care Medical Necessity Criteria:**

- Medications in this policy will be administered in a place of service that is a non-hospital facility based location (i.e., home infusion provider, provider's office, free-standing ambulatory infusion center) unless *at least one* of the following are met†:

    1. Age less than 18* years; or
    2. Clinically unstable based upon documented medical history (e.g., patient is hemodynamically unstable); or
    3. History of a severe adverse event from previous administration of the prescribed medication; or

4. Requested medication is being administered as follows:
    - part of a chemotherapy regimen (e.g., anti-neoplastic agent, colony stimulating factor, erythropoiesis-stimulating agent, anti-emetic) for treatment of cancer; or
    - administered with dialysis; or
5. Physical or cognitive impairment and caregiver is not available to assist with safe administration of prescribed medication in the home; or
6. Experiencing adverse events that are not managed by premedication or resources available at a non-hospital facility based location.

No initial doses are allowed in a hospital based outpatient facility without other above criteria being met.

* Effective 01/01/2019, age criterion applies to 18 years of older. Age at original effective date (03/01/2016) was 21 years or older.

†This criterion does not apply to Medicare or Medicare Advantage members.

Prior approval is required for HCPCS Codes J3490 and J3590

†When *unclassified drugs* (J3490) or *unclassified biologics* (J3590) is determined to be Dupixent

HCPCS Code(s):	
J3490	Unclassified drugs
J3590	Unclassified Biologics