Connecticut Department of Social Services
Medical Assistance Program **Provider Bulletin 2022-28**
www.ctdssmap.com **March 2022**

TO: Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants

RE: New Dupixent® Prior Authorization Clinical Criteria Requirements

Effective May 4, 2022, the Department of Social Services (DSS) will implement a Prior Authorization (PA) requirement for prescription benefit coverage of dupilumab injection, marketed as Dupixent®, for HUSKY A, B, C and D members.

The U.S. Food and Drug Administration (FDA) approved indications for Dupixent® (dupilumab) injection include:

- Moderate to severe atopic dermatitis (aged 6+)
- Moderate to severe asthma (aged 6+)
- Chronic rhinosinusitis with nasal polyposis (aged 18+)

Primary treatment guidelines should be followed before a member is prescribed Dupixent® (dupilumab) injection.

Prior Authorization (PA) Requirements

Clinical criteria for PA approval for dupilumab is as follows:

Uncontrolled Moderate-to-Severe Atopic Dermatitis:

1. The patient must be age 6 or older
2. The patient must have a diagnosis of moderate to severe atopic dermatitis unresponsive to topical prescription therapy alone and for whom phototherapy is not feasible or acceptable and failed previous treatment with conventional immunosuppressive agents, such as cyclosporine, methotrexate, mycophenolate mofetil, or azathioprine

Moderate-to-Severe Asthma:

1. The patient must be age 6 or older
2. The patient must have a diagnosis of eosinophilic phenotype asthma (eg, peripheral blood eosinophils ≥150/microL) and is oral corticosteroid dependent and not controlled on maximum inhaled GC/LAMA/LABA therapy

Inadequately Controlled Chronic Rhinosinusitis with Nasal Polyposis:

1. The patient must be age 18 or older
2. The patient must have a diagnosis of chronic rhinosinusitis with nasal polyposis and has failed to be controlled by a course of systemic corticosteroids or history of sinus surgery followed by topical corticosteroid treatment

The new Dupixent PA form will be available on the www.ctdssmap.com Web site. From the Home page, go to Information > Publications > Authorization/Certification Forms > Dupixent PA Form; or from the Home page, go to Pharmacy Information > Pharmacy Program Publications > Dupixent PA Form.

When the clinical criteria is met, the completed form should be faxed to one of the numbers listed on the top of the form.

In instances where the individual does **NOT meet these criteria, the prescriber must write a letter of medical necessity to DSS' Medical Director for consideration. Letters of medical necessity can be emailed with the Dupixent PA form to Rx.LMN@ct.gov with all relevant information relating to the medical necessity**.

Members who have an approved active PA and are receiving Dupixent® will be authorized to receive Dupixent® for the remainder of the existing PA. At the expiration of the PA, prescribers will need to submit a new prior authorization request utilizing the Dupixent® PA form if the member is required to continue treatment.

Please note that PAs submitted and approved through the use of the new Dupixent® Prior Authorization form will be authorized for a period of twelve (12) months.