

## Louisiana Medicaid Atopic Dermatitis Immunomodulators

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Prior authorization for non-preferred atopic dermatitis immunomodulators; **OR**
- Clinical authorization for dupilumab (Dupixent<sup>®</sup>), lebrikizumab-lbkz (Ebglyss<sup>™</sup>), nemolizumab-iltio (Nemluvio<sup>®</sup>), or tralokinumab-ldrm (Adbry<sup>®</sup>).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available [HERE](#).

*When currently posted criteria are not met, a clinical reviewer will consider the most current FDA-approved prescribing information for the requested agent when evaluating the request.*

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### Non-Preferred Atopic Dermatitis Immunomodulators (Except Dupixent<sup>®</sup>, Ebglyss<sup>™</sup>, Nemluvio<sup>®</sup> and Adbry<sup>®</sup>)

#### Approval Criteria for Initiation and Continuation of Therapy

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.

#### Duration of approval for initiation and continuation of therapy: 2 weeks to 6 months

*An appropriate duration of initial authorization and reauthorization approval (if needed) will be determined based upon patient-specific factors and the condition being treated.*

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### Dupilumab (Dupixent<sup>®</sup>)

#### Approval Criteria for Initiation of Therapy for Atopic Dermatitis

- The recipient is 6 months of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- There has been a treatment failure or intolerable side effect with or contraindication to a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**

- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a treatment failure with at least one preferred product; **OR**
  - The recipient has had an intolerable side effect to at least one preferred product; **OR**
  - The recipient has documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is no preferred product that is appropriate to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Atopic Dermatitis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of AD.

### **Approval Criteria for Initiation of Therapy for Allergic Fungal Rhinosinusitis**

- The recipient is 6 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of allergic fungal rhinosinusitis (AFRS) confirmed by **ALL** of the following: (must be **stated on the request**)
  - Evidence of Type 1 hypersensitivity to a fungus by skin prick test or serum IgE testing; **AND**
  - Nasal polyposis confirmed by nasal endoscopy; **AND**
  - Characteristic computed tomography (CT) scan findings (e.g. hyperdensities, bony demineralization, or bone erosion of sinuses); **AND**
  - Presence of eosinophilic mucin without invasion into the sinus tissue; **AND**
  - Positive fungal stain of sinus contents; **AND**
- The recipient has a history of sino-nasal surgery (surgery date must be **stated on the request**); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, an allergist or otolaryngologist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a treatment failure with at least one preferred product; **OR**
  - The recipient has had an intolerable side effect to at least one preferred product; **OR**
  - The recipient has documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is no preferred product that is appropriate to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Allergic Fungal Rhinosinusitis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy.

### **Approval Criteria for Initiation of Therapy for Moderate to Severe Asthma with an Eosinophilic Phenotype**

- The recipient is 6 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe asthma with an eosinophilic phenotype; **AND**
- The recipient has a baseline blood eosinophil count of  $\geq 150$  cells/ $\mu$ L within the previous 3 months (Date and results must be **stated on the request**); **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., inhaled corticosteroids (ICS), long-acting beta-agonists (LABA), combination ICS/LABA; leukotriene modifiers); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a pulmonologist, immunologist or allergist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a treatment failure with at least one preferred product; **OR**
  - The recipient has had an intolerable side effect to at least one preferred product; **OR**
  - The recipient has documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is no preferred product that is appropriate to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Moderate to Severe Asthma with an Eosinophilic Phenotype**

- The prescriber **states on the request** that there is evidence of a positive response to therapy by one of the following:
  - Decrease in the frequency of asthma exacerbations; **OR**
  - Decrease in the use of rescue medications; **OR**
  - Reduction in asthma-related symptoms; **OR**
  - Increase in FEV1 percent predicted; **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., inhaled corticosteroids (ICS), long-acting beta-agonists (LABA), combination ICS/LABA; leukotriene modifiers).

### **Approval Criteria for Initiation of Therapy for Corticosteroid-Dependent Asthma**

- The recipient is 6 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of corticosteroid-dependent asthma; **AND**
- The recipient requires daily oral corticosteroid treatment for at least three months (Medication name and date range of therapy are **stated on the request**); **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., inhaled

corticosteroids (ICS), long-acting beta-agonists (LABA), combination ICS/LABA; leukotriene modifiers); **AND**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a pulmonologist, immunologist or allergist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a treatment failure with at least one preferred product; **OR**
  - The recipient has had an intolerable side effect to at least one preferred product; **OR**
  - The recipient has documented contraindication(s) to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is no preferred product that is appropriate to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Corticosteroid-Dependent Asthma**

- The prescriber states on the request that the recipient has been able to maintain asthma control while taking a lower dose of daily oral corticosteroid compared to baseline dose; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to therapy by one of the following:
  - Decrease in the frequency of asthma exacerbations; **OR**
  - Decrease in the use of rescue medications; **OR**
  - Reduction in asthma-related symptoms; **OR**
  - Increase in FEV1 percent predicted; **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., inhaled corticosteroids (ICS), long-acting beta-agonists (LABA), combination ICS/LABA; leukotriene modifiers).

### **Approval Criteria for Initiation of Therapy for Chronic Rhinosinusitis with Nasal Polyposis**

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of chronic rhinosinusitis with nasal polyposis; **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., intranasal corticosteroids); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, an allergist or otolaryngologist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**

- The requested dose and dosing frequency are appropriate for the recipient’s age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Chronic Rhinosinusitis with Nasal Polyposis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy by reduction in nasal polyp size or severity of congestion compared to the recipient’s baseline prior to initiation of Dupixent®; **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with other controller medications (e.g., intranasal corticosteroids).

### **Approval Criteria for Initiation of Therapy for Eosinophilic Esophagitis**

- The recipient is 1 year of age or older on the date of the request; **AND**
- The recipient weighs at least 15 kg (33 lbs) [weight of recipient must be **stated on the request**]; **AND**
- The recipient has a diagnosis of eosinophilic esophagitis; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, an allergist or gastroenterologist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient’s age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Eosinophilic Esophagitis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy.

### **Approval Criteria for Initiation of Therapy for Prurigo Nodularis**

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of prurigo nodularis (PN); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**

- There has been a treatment failure or intolerable side effect with or contraindication to a preferred super-potent topical corticosteroid agent (see Dermatology – Steroids, Topical – High and Very High Potency); **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient’s age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Prurigo Nodularis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of PN.

### **Approval Criteria for Initiation of Therapy for Chronic Obstructive Pulmonary Disease (COPD) with an Eosinophilic Phenotype**

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of COPD with an eosinophilic phenotype; **AND**
- The recipient has a baseline blood eosinophil count of  $\geq 300$  cells/ $\mu$ L within the previous 3 months (Date and results must be **stated on the request**); **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) [unless contraindicated]; **AND**
- The recipient has been compliant for at least 3 consecutive months with optimized pharmacotherapy for the treatment of COPD, which is **stated on the request**; **AND**
- Even with compliant use of optimized pharmacotherapy for at least 3 consecutive months, the recipient’s COPD continues to be uncontrolled as defined by **ONE** of the following which is **stated on the request**:
  - The recipient required treatment with systemic corticosteroids and/or antibiotics; **OR**
  - The recipient was hospitalized or in observation for over 24 hours in an emergency department or urgent care facility; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a pulmonologist, immunologist or allergist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**

- There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Chronic Obstructive Pulmonary Disease (COPD) with an Eosinophilic Phenotype**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a reduction in COPD exacerbations; **AND**
- The prescriber **states on the request** that the recipient is using Dupixent® (dupilumab) as an add-on maintenance treatment in combination with maintenance triple therapy consisting of a long-acting muscarinic antagonist (LAMA), long-acting beta agonist (LABA), and inhaled corticosteroid (ICS) [unless contraindicated].

### **Approval Criteria for Initiation of Therapy for Chronic Spontaneous Urticaria**

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of chronic spontaneous urticaria; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- The recipient has been adherent to H1 antihistamine therapy for a minimum of 4 weeks but is still symptomatic. [Each medication and date range of treatment must be **stated on the request**. Adherence to drug therapy will be validated through claims data review]; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### **Approval Criteria for Continuation of Therapy for Chronic Spontaneous Urticaria**

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

### **Approval Criteria for Initiation of Therapy for Bullous Pemphigoid**

- The recipient is 18 years of age or older on the date of the request; **AND**

- The recipient has a confirmed diagnosis of bullous pemphigoid (BP) based on objective clinical evidence consistent with the diagnosis and positive findings using **ONE** of the following modalities:
  - Direct immunofluorescence microscopy (DIF); **OR**
  - Indirect immunofluorescence (IIF) microscopy; **OR**
  - Enzyme-linked immunosorbent assay (ELISA); **AND**
- The disease state is moderate to severe confirmed by a Bullous Pemphigoid Disease Area Index (BPDAI) activity score  $\geq 20$ ; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **AND**
- The requested dose and dosing frequency are appropriate for the recipient's age, weight and diagnosis based on the prescribing information.

### Approval Criteria for Continuation of Therapy for Bullous Pemphigoid

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

**Duration of approval for initiation of therapy: 6 months**

**Duration of approval for continuation of therapy: 12 months**

### Lebrikizumab-lbkz (Ebglyss™)

#### Approval Criteria for Initiation of Therapy

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient weighs at least 40 kg (88 lbs) [weight of recipient must be **stated on the request**]; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- **ONE** of the following:
  - There has been a treatment failure or intolerable side effect with a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency) (names and dates of medications must be **stated on the request**); **OR**
  - The recipient has a contraindication to **ALL** preferred topical corticosteroid agents; **AND**

- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.

### Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of AD; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

**Duration of approval for initiation of therapy: 6 months**

**Duration of approval for continuation of therapy: 12 months**

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### Nemolizumab-ilto (Nemluvio®)

#### Approval Criteria for Initiation of Therapy for Prurigo Nodularis

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of prurigo nodularis (PN); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- **ONE** of the following:
  - There has been a treatment failure or intolerable side effect with a preferred super-potent topical corticosteroid agent (see Dermatology – Steroids, Topical – High and Very High Potency); **OR**
  - The recipient has a contraindication to **ALL** preferred super-potent topical corticosteroid agents (see Dermatology – Steroids, Topical – High and Very High Potency); **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**

- If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.

### **Approval Criteria for Continuation of Therapy for Prurigo Nodularis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of PN; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

### **Approval Criteria for Initiation of Therapy for Atopic Dermatitis**

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- **ONE** of the following:
  - There has been a treatment failure or intolerable side effect with a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – High and Very High Potency) or a preferred topical calcineurin inhibitor (see Dermatology – Atopic Dermatitis Immunomodulators); **OR**
  - The recipient has a contraindication to **ALL** topical corticosteroid agents (see Dermatology – Steroids, Topical – High and Very High Potency) and topical calcineurin inhibitors (see Dermatology – Atopic Dermatitis Immunomodulators); **AND**
- The requested medication is prescribed concurrently with a topical corticosteroid and/or topical calcineurin inhibitor, unless contraindicated or clinically significant adverse effects are experienced; **AND**
  - The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor; **AND**
  - If request is for a non-preferred agent - **ONE** of the following is required: (see Dermatology – Atopic Dermatitis Immunomodulators on the PDL/NPDL for a list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**

- The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
- The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
- There is *no preferred product that is appropriate* to use for the condition being treated.

### **Approval Criteria for Continuation of Therapy for Atopic Dermatitis**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of AD; **AND**
- The prescriber **states on the request** that the medication requested is not prescribed concurrently with another biologic immunomodulator or JAK inhibitor.

**Duration of approval for initiation of therapy: 6 months**

**Duration of approval for continuation of therapy: 12 months**

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### **Tralokinumab-ldrm (Adbry®)**

#### **Approval Criteria for Initiation of Therapy**

- The recipient is 12 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe atopic dermatitis (AD); **AND**
- There has been a treatment failure or intolerable side effect with or contraindication to a preferred topical corticosteroid agent (see Dermatology – Steroids, Topical – Low, Medium, High and Very High Potency) (names and dates of medications must be **stated on the request**); **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist or allergist; **AND**
- If request is for a non-preferred agent - **ONE** of the following is required:
  - The recipient has had a *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has *documented contraindication(s)* to all of the preferred products that are appropriate to use for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated.

#### **Approval Criteria for Continuation of Therapy**

- The prescriber **states on the request** that there is evidence of a positive response to therapy including a significant reduction in areas affected and/or severity of atopic dermatitis.

## Duration of approval for initiation and continuation of therapy: 6 months

### References

Adbry (tralokinumab-ldrm) [package insert]. Madison, NJ: LEO Pharma Inc; December 2023.  
<https://www.leo-pharma.us/Files/Billeder/US%20Website%20Product%20PIs/AdbryPI.pdf>

Boguniewicz M, Alexis AF, Beck LA, Block J, Eichenfield LF, Fonacier L, Guttman-Yassky E, Paller AS, Pariser D, Silverberg JI, Lebwohl M. Expert Perspectives on Management of Moderate-to-Severe Atopic Dermatitis: A Multidisciplinary Consensus Addressing Current and Emerging Therapies. *J Allergy Clin Immunol Pract*. 2017 Nov-Dec;5(6):1519-1531. doi: 10.1016/j.jaip.2017.08.005. Epub 2017 Sep 29. PMID: 28970084.

C. Feliciani et al. Management of bullous pemphigoid: the European Dermatology Forum consensus in collaboration with the European Academy of Dermatology and Venereology, *British Journal of Dermatology*, Volume 172, Issue 4, 1 April 2015, Pages 867–877, <https://doi.org/10.1111/bjd.13717>

Chu, Derek K. et al. Atopic dermatitis (eczema) guidelines: 2023 American Academy of Allergy, Asthma and Immunology/American College of Allergy, Asthma and Immunology Joint Task Force on Practice Parameters GRADE– and Institute of Medicine–based recommendations. *Annals of Allergy, Asthma & Immunology*. 2023;(132)3:274 – 312.

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.;  
<https://www.clinicalkey.com/pharmacology/>

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. *Pharmacotherapy: A Pathophysiologic Approach*, 10e New York, NY: McGraw-Hill;  
<https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861>

Dupixent (dupilumab) [package insert]. Bridgewater, NJ: sanofi-aventis U.S. LLC; ~~February~~ ~~June~~ 2024. [https://www.regeneron.com/sites/default/files/Dupixent\\_FPI.pdf](https://www.regeneron.com/sites/default/files/Dupixent_FPI.pdf)

Ebglyss (lebrikizumab-lbkz) [package insert]. Indianapolis, IN: Eli Lilly and Company; September 2024. <https://pi.lilly.com/us/ebglyss-uspi.pdf?s=pi>

Glass D, Amedee RG. Allergic fungal rhinosinusitis: a review. *Ochsner J*. 2011 Fall;11(3):271-5. PMID: 21960761; PMCID: PMC3179194.

Masmoudi W et al. EADV Autoimmune Bullous Skin Disease Task Force. International validation of the Bullous Pemphigoid Disease Area Index severity score and calculation of cut-off values for defining mild, moderate and severe types of bullous pemphigoid. *Br J Dermatol*. 2021 Jun;184(6):1106-1112. doi: 10.1111/bjd.19611. Epub 2020 Nov 29. PMID: 33067805.

Nemluvio (nemolizumab-ilt) [package insert]. Dallas, TX: Galderma Laboratories; December 2024.  
[https://www.galderma.com/sites/default/files/2024-12/Nemluvio\\_Dual%20PI%20for%20website%2013Dec24.pdf](https://www.galderma.com/sites/default/files/2024-12/Nemluvio_Dual%20PI%20for%20website%2013Dec24.pdf)

Satoh T, Yokozeki H, Murota H, et al. 2020 guidelines for the diagnosis and treatment of prurigo. *J Dermatol.* 2021;48(9):e414-e431. doi:10.1111/1346-8138.16067

<b>Revision / Date</b>	<b>Implementation Date</b>
Single PDL Implementation	May 2019
Separated “Select Therapeutic Classes Not Established” into individual therapeutic class documents / November 2019	January 2020
Added reference to Dupixent® criteria document / December 2019	January 2020
Added revision table, removed footer, combined atopic dermatitis immunomodulators criteria and Dupixent® criteria into one document / January 2020	January 2020
Added topical corticosteroid treatment failure and modified age for Dupixent® for atopic dermatitis, formatting changes, updated references / June 2020	October 2020
Added preferred brand Elidel® wording, formatting changes, updated references / November 2020	January 2021
Updated Dupixent® criteria to include prescriber specialty, modified reauthorization criteria, added eosinophilic requirements for asthma, modified authorization duration, formatting changes / July 2021	January 2022
Decreased Dupixent® age for asthma to 6 years of age / October 2021	January 2022
Combined Adbry™ with current criteria, updated references / May 2022	July 2022
Added indication of eosinophilic esophagitis for Dupixent®, modified age of atopic dermatitis for Dupixent®, updated references / May 2022	October 2022
Formatting change to Elidel® wording, modified duration of therapy for Dupixent® / November 2022	January 2023
Added indication of prurigo nodularis for Dupixent®, previous use policy clarification, updated references / October 2022	April 2023
Modified age for atopic dermatitis for Adbry®, modified age and weight for eosinophilic esophagitis for Dupixent®, removed specific wording for the use of Elidel®, updated references, formatting changes / February 2024	July 2024
Added statement for clinical review of most recent prescribing information when currently posted criteria are not met / October 2024	November 2024
Added indication of COPD for Dupixent®, modified age of chronic rhinosinusitis for Dupixent®, updated references / November 2024	March 2025
Combined Ebglyss®™ and Nemluvio® with current criteria document / May 2025	July 2025
Added indications of chronic spontaneous urticaria and bullous pemphigoid for Dupixent®, updated references / June 2025	January 2026
<u>Added indication of allergic fungal rhinosinusitis for Dupixent®, updated references / March 2026</u>	<u>July 2026</u>