Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Dupixent® (dupilumab)**

Effective: September 1, 2026

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Dupixent (dupilumab) is an interleukin-4 receptor alpha agonist indicated:

Disease State	
Allergic Fungal Rhinosinusitis	X
Asthma	X
Atopic Dermatitis	X
Bullous Pemphigoid	X
Chronic Rhinosinusitis with Nasal Polyps	X
Chronic Obstructive Pulmonary Disease	X
Chronic Spontaneous Urticaria	X
Eosinophilic Esophagitis	X
Prurigo Nodularis	X

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Dupixent for Members when **ALL** of the following criteria are met:

Allergic Fungal Rhinosinusitis

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of allergic fungal rhinosinusitis

AND

2. Patient is six (6) years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

AND

4. Documentation the patient has had at least one prior sino-nasal surgery

AND

5. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of allergic fungal rhinosinusitis

AND

2. Patient is six (6) years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

AND

4. Submission of medical charts documenting the patient has experienced a therapeutic response as defined by **one (1)** of the following:
    a. Reduced nasal polyp size
    b. Reduced sinus opacification
    c. Improved nasal congestion
    d. Decreased sinonasal symptoms
    e. Improved sense of smell
    f. Reduced use of systemic corticosteroids

AND

5. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Asthma

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of moderate to severe asthma with **one (1)** of the following:
    a. Pre-treatment peripheral blood eosinophil level greater than or equal to 150 cells per microliter
    b. Dependence on oral corticosteroid for the treatment of asthma for at least six (6) months

AND

2. Patient is six (6) years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

AND

4. Documentation of **one (1)** of the following within the previous 12 months:
    a. History of two (2) or more asthma exacerbations requiring systemic corticosteroids
    b. Prior asthma-related hospitalizations

AND

5. Documentation of history of failure to a minimum of three (3) month trial with a maximally tolerated inhaled corticosteroid plus at least one other asthma maintenance medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated

AND

6. Documentation the requested medication will be used as add-on maintenance therapy with a maximally tolerated inhaled corticosteroid plus at least one other asthma maintenance medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated

AND

7. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of **one (1)** of the following:
    a. Moderate to severe asthma of eosinophilic phenotype
    b. Corticosteroid dependent asthma

AND

2. Patient is six (6) years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or pulmonologist

AND

4. Submission of medical charts documenting the patient has experienced a therapeutic response as defined by **one (1)** of the following:

a. Increase in percent predicted Forced Expiratory Volume (FEV1) from pretreatment baseline
b. Reduction in the dose of inhaled corticosteroids required to control asthma
c. Reduction in asthma exacerbations (e.g., decreased frequency of use of unscheduled emergency department/urgent care visits)
d. Reduction in asthma symptoms (e.g., chest tightness, coughing, shortness of breath, or nocturnal awakenings)
e. Reduction in the use of oral corticosteroids to treat and/or prevent asthma exacerbations

AND

5. Documentation the requested medication will be used as add-on maintenance therapy with a maximally tolerated inhaled corticosteroid plus at least one other asthma maintenance medication (e.g., long-acting inhaled beta2-agonist, long-acting muscarinic antagonist, leukotriene receptor antagonist), unless contraindicated)

AND

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Atopic Dermatitis

Initial Authorization Criteria

1. Documented diagnosis of moderate to severe atopic dermatitis

AND

2. Documentation the patient's condition meets **one (1)** of the following:
   a. Body Surface Area (BSA) of at least 10%
   b. Eczema Area and Severity Index EASI score of at least 16
   c. Investigator's Global Assessment/Physician Global Assessment (IGA/PGA) score of at least 3

AND

3. Patient is at least 6 months of age or older

AND

4. Prescribed by a dermatologist, allergist, or immunologist

AND

5. Documentation of history of failure to a minimum 30-day supply (14-day supply for topical corticosteroids) to **one (1)** of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced: medium or high potency topical corticosteroids, calcineurin inhibitor, crisaborole, ruxolitinib *(Note: document drug, date and duration)*

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of moderate to severe atopic dermatitis

AND

3. Patient is at least 6 months of age

AND

4. Prescribed by a dermatologist, allergist, or immunologist

AND

5. Documentation the patient has experienced a beneficial clinical response, defined as improvement from baseline in at least **one (1)** of the following:
   a. Estimated body surface area affected by atopic dermatitis, erythema, induration/thickness, and/or scale of areas affected by atopic dermatitis
   b. Reduction in the use of other topical or systemic therapies

AND

6. Documentation that compared to baseline, the patient has experienced an improvement in at least one symptom of atopic dermatitis such as pruritus, xerosis, crusting, or lichenification

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Bullous Pemphigoid

Initial Authorization Criteria

1. Documented diagnosis of bullous pemphigoid

AND

2. Documentation diagnosis is confirmed by skin biopsy or serologic study

AND

3. Patient is at least 18 years old or older

AND

4. Prescribed by a dermatologist

AND

5. Documentation Dupixent will be used in combination with a tapering course of oral corticosteroids until disease control has occurred, unless contraindicated

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of bullous pemphigoid

AND

3. Patient is at least 18 years old or older

AND

4. Prescribed by a dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined as an improvement from baseline in lesion formation or lesion healing

AND

6. Submission on medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of bullous pemphigoid such as erythema, pruritus or pain

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Chronic Obstructive Pulmonary Disease (COPD)

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of chronic obstructive pulmonary disease

AND

2. Documentation of presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter

AND

3. Documentation of moderate to severe airflow limitation as evidenced by **both** of the following:
    a. Post-bronchodilator forced expiratory volume in one second (FEV1)/forced vital capacity (FVC) ratio less than 0.70
    b. Post-bronchodilator forced expiratory volume in one second (FEV1) of 30% to 70%

AND

4. Documentation of **one (1)** of the following within the previous 12 months:
    a. At least two (2) moderate exacerbations defined as treatment with either systemic corticosteroids and/or antibiotics
    b. At least one (1) severe exacerbation defined as requiring hospitalization or observation for over 24 hours in an emergency department or urgent care facility

AND

5. Patient is 18 years of age or older

AND

6. Prescribed by or in consultation with a pulmonologist

AND

7. Documentation of history of failure with a maximally tolerated regimen on **one (1)** of the following, unless contraindicated:
    a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta

agonist
   b. Dual therapy with a long-acting muscarinic antagonist and a long-acting beta agonist due to contraindication to inhaled corticosteroids

AND

8. Documentation the requested medication will be used as add-on maintenance therapy in combination with **one (1)** of the following, unless contraindicated:
   a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta agonist
   b. Dual therapy with a long-acting muscarinic antagonist and a long-acting beta agonist due to contraindication to inhaled corticosteroids

AND

9. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of moderate to severe chronic obstructive pulmonary disease and an eosinophilic phenotype

AND

2. Patient is 18 years of age or older

AND

3. Prescribed by or in consultation with a pulmonologist

AND

4. Submission of medical charts documenting the Member has experienced a therapeutic response to therapy defined by **one (1)** of the following:
   a. Reduction in the frequency of COPD exacerbations
   b. Increase in percent predicted FEV1 from pretreatment baseline
   c. Reduction in severity or frequency of COPD-related symptoms (e.g., dyspnea, wheezing, cough, sputum volume, decrease in sputum purulence)
   d. Reduction in oral corticosteroid requirements

AND

5. Documentation the requested medication will be used as add-on maintenance therapy in combination with one (1) of the following, unless contraindicated:
   a. Triple therapy regimen with an inhaled corticosteroid, a long-acting muscarinic antagonist, and a long-acting beta agonist
   b. Dual therapy with a long-acting muscarinic antagonist and long-acting beta agonist due to contraindication to inhaled corticosteroids

AND

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of chronic rhinosinusitis with nasal polyps

AND

2. Patient is 12 years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

AND

4. Documentation of history of failure to a minimum eight (8) week trial of intranasal corticosteroids, unless contraindicated

AND

5. Documentation the requested medication will be used as add-on maintenance therapy with intranasal corticosteroids, unless contraindicated

AND

6. Documentation the patient is not receiving the requested medication in combination with any of the following:

a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
b. Anti-IgE therapy (e.g., omalizumab)
c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of chronic rhinosinusitis with nasal polyps

AND

2. Patient is 12 years of age or older

AND

3. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist

AND

4. Documentation the requested medication will be used as add-on maintenance therapy with intranasal corticosteroids, unless contraindicated

AND

5. Submission of medical charts documenting the patient has experienced a therapeutic response to therapy as defined by at least **one (1)** of the following:
   a. Adequate sinus ventilation and drainage
   b. Control of mucosal inflammation and edema
   c. Reduction in exacerbations

AND

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Chronic Spontaneous Urticaria

Initial Authorization Criteria

1. Submission of medical charts documenting a diagnosis of chronic spontaneous urticaria

AND

2. Documentation of persistent symptoms of chronic spontaneous urticaria for at least six (6) weeks despite use of a second generation H1 antihistamine, unless contraindicated

AND

3. Patient is 2 years of age or older

AND

4. Prescribed by or in consultation with an allergist, dermatologist, or immunologist

AND

5. Documentation of history of failure to a minimum two (2) week trial with a second-generation H1 antihistamine (e.g., cetirizine, fexofenadine, levocetirizine, loratadine), unless contraindicated

AND

6. Documentation the requested medication will be used concurrently with a second-generation H1 antihistamine, unless contraindicated

AND

7. Documentation the patient is not receiving the requested medication in combination with any of the following:
   a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
   b. Anti-IgE therapy (e.g., omalizumab)
   c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of chronic idiopathic urticaria

AND

2. Patient is 2 years of age or older

AND

3. Prescribed by or in consultation with an allergist, dermatologist, or immunologist

AND

4. Submission of medical charts documenting the patient has experienced a therapeutic response to therapy as defined by **one (1)** of the following:
   a. Reduced itching

b. Reduction in the number and/or size of hives

AND

5. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Eosinophilic Esophagitis

Initial Authorization Criteria

1. Submission of medical records documenting a diagnosis of eosinophilic esophagitis as evidenced by **both** of the following:
    a. Chronic symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, food refusal, abdominal pain, heartburn, regurgitation, chest pain, odynophagia)
    b. Peak value of at least 15 intraepithelial eosinophils per high power field

AND

2. Documentation that other causes of esophageal eosinophilia have been excluded

AND

3. The patient is 1 year old or older

AND

4. The patient weighs at least 15 kg

AND

5. Prescribed by or in consultation with an allergist, immunologist, or gastroenterologist

AND

6. Documentation of history of failure to a minimum eight (8) week trial of a proton pump inhibitor, unless contraindicated

AND

7. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Reauthorization Criteria

1. Documented diagnosis of eosinophilic esophagitis

AND

2. The patient is 1 year old or older

AND

3. The patient weighs at least 15 kg

AND

4. Prescribed by or in consultation with an allergist, immunologist, or gastroenterologist

AND

5. Submission of medical charts documenting the patient has experienced a therapeutic response as defined by **one (1)** of the following:
    a. Decreased peak esophageal intraepithelial eosinophil count from baseline
    b. Improvement in symptoms of esophageal dysfunction (e.g., dysphagia, pain upon swallowing, food impaction)
    c. Improvement in endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

6. Documentation the patient is not receiving the requested medication in combination with any of the following:
    a. Anti-interleukin-5 therapy (e.g., benralizumab, mepolizumab, reslizumab)
    b. Anti-IgE therapy (e.g., omalizumab)
    c. Thymic stromal lymphopoietin (TSLP) inhibitor (e.g., tezepelumab)

Prurigo Nodularis

Initial Authorization Criteria

1. Documented diagnosis of prurigo nodularis as evidenced by **one (1)** of the following:
    a. All of the following:
        i. Prescence of firm, nodular lesions
        ii. Pruritis lasting at least six weeks
        iii. History and/or signs of repeated scratching, picking, or rubbing

b. Skin biopsy confirming prurigo nodularis

AND

2. The patient is 18 years of age or older

AND

3. Prescribed by a dermatologist, allergist or immunologist

AND

4. Documentation of poor control requiring additional treatment despite a minimum 14-day supply of **one (1)** medium to super high potency topical corticosteroid, unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date and duration of trial)*

AND

5. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least six (6) months

AND

2. Documented diagnosis of prurigo nodularis

AND

3. Patient is 18 years of age or older

AND

4. Prescribed by a dermatologist allergist or immunologist

AND

5. Submission on medical charts documenting the patient experienced a beneficial clinical response defined as an improvement from baseline in nodular lesion count, nodular lesion size, or itching

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Limitations

1. Initial approval of Dupixent will be authorized for six (6) months. Reauthorization of Dupixent will be provided in 12-month intervals.
2. Atopic dermatitis, bullous pemphigoid, and prurigo nodularis:
    - A patient who has received less than six (6) months of therapy or who is restarting therapy with the requested drug is reviewed under Initial Authorization Criteria.
    - Members new to the plan stable on the requested medication should be reviewed against Initial Authorization Criteria.
3. Allergic fungal rhinosinusitis, asthma, chronic obstructive pulmonary disease, chronic rhinosinusitis with nasal polyps, chronic spontaneous urticaria, and eosinophilic esophagitis
    - Members new to the plan stable on the requested medication should be reviewed against Reauthorization Criteria.
4. Members who have already initiated the requested medication using samples, free goods, similar offerings, or self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against Initial Authorization Criteria.

Codes

None

References

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11. Rabe KF, Nair P, Brusselle G, et al. Efficacy and safety of dupilumab in glucocorticoid-dependent severe asthma. N Engl J Med. 2018 Jun 28;378(26):2475-85.
12. Stander S et al. IFSI-guideline on chronic prurigo including prurigo nodularis. Itch. 2020;5:e2.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

1. October 2022 e-vote: For eosinophilic esophagitis, updated to include in consultation with prescriber specialist, including immunologist. Updated language of PPI trial to include intolerance or contraindication.
2. February 14, 2023: Added coverage criteria for the supplemental indication of prurigo nodularis (effective March 1, 2023).
3. February 13, 2024: Updated age requirements for eosinophilic esophagitis based on updated FDA-approved labeling (eff 3/1/24).
4. May 14, 2024: For chronic rhinosinusitis with nasal polyps updated diagnosis requirements to a documented diagnosis of chronic rhinosinusitis with nasal polyps and removed documentation the patient remains symptomatic despite treatment with an intranasal corticosteroid or contraindication to intranasal corticosteroids (eff 6/1/2024).
5. October 8, 2024: Updated age requirements for chronic rhinosinusitis with nasal polyps based on updated FDA-approved labeling (eff 11/1/24).
6. December 10, 2024: Added coverage criteria for chronic obstructive pulmonary disorder (eff 2/1/25).
7. October 14, 2025: Added coverage criteria for bullous pemphigoid and chronic spontaneous urticaria. For atopic dermatitis and prurigo nodularis, provider requirements no longer allow with in consultation with the specialist, added coverage criteria to prevent duplicative targeted immunomodulator therapy, updated Reauthorization criteria. Updated Limitation language for how members new to the plan should be reviewed for all indications (eff 1/1/26).
8. May 12, 2026: Added coverage criteria for allergic fungal rhinosinusitis. Removed the Limitation: Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinical inappropriateness to methotrexate therapy. For CSU, updated age requirements to at least 2 years of age and removed “Documentation Dupixent will be used concurrently with a second generation H1 antihistamine, unless contraindicated” from Reauthorization Criteria (eff 6/1/26).
9. June 9, 2026: Effective July 1, 2026: For bullous pemphigoid, removed history of failure to at least one corticosteroid and non-steroidal immunosuppressive. Administrative update to remove Carelink from the Medical Necessity Guideline template (eff 7/1/26). Effective September 1, 2026: For allergic fungal rhinosinusitis added submission of medical charts confirming diagnosis (initial), added concurrent therapy language (Initial and Reauthorization), and added submission of medical charts confirming objective reauthorization criteria (Reauthorization). For Asthma added submission of medical charts confirming diagnosis (Initial), removed current treatment with an alternative respiratory biologic as confirmation of diagnosis (Initial), added severity requirements (history of exacerbations or hospitalization), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), enhanced concurrent therapy language (Initial and Reauthorization), added confirmation treatment will be used as add-on therapy (Reauthorization), and added submission of medical charts confirming objective reauthorization criteria (Reauthorization). For Chronic Rhinosinusitis with Nasal Polyps added additional objective responses to therapy in objective reauthorization criteria (Reauthorization), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added minimum treatment duration of non-biologic prerequisites (Initial), enhanced concurrent therapy language (Initial and Reauthorization), and submission of medical charts confirming objective reauthorization criteria (Reauthorization). For Chronic Obstructive Pulmonary Disorder added submission of medical charts confirming diagnosis (Initial), added documentation of moderate to severe airway limitation using two Spirometry requirements (Initial), separated confirmation of history of failure of inhaler prerequisites and requested use as add-on therapy to inhalers (Initial), added concurrent therapy language (Initial and Reauthorization), added submission of medical charts confirming objective reauthorization criteria (Reauthorization), and added additional objective responses to therapy in objective reauthorization criteria (Reauthorization). For CSU added submission of medical charts confirming diagnosis (Initial), added concurrent therapy language (Initial and Reauthorization), removed requirement for concurrent use with an antihistamine from Reauthorization Criteria, and added submission of medical charts confirming objective reauthorization criteria (Reauthorization). For EoE added submission of medical charts confirming diagnosis

(Initial), added rule out criteria (Initial), added concurrent therapy language (Initial and Reauthorization), Added submission of medical charts confirming objective reauthorization criteria (Reauthorization), and added additional objective responses to therapy in objective reauthorization criteria (Reauthorization). Added limitation statement that members who have already initiated the requested medication using samples, free goods, similar offerings, or self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against Initial Authorization Criteria. (eff 9/1/26).

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.