



## Missouri Pharmacy Program – Preferred Drug List



### Atopic Dermatitis Agents (Immunomodulators)

Effective 03/20/2008

Revised 07/12/2018

#### Preferred Agents

- Elidel®
- Eucrisa®

#### Non-Preferred Agents

- Dupixent® (SQ Injection)
- Protopic®
- Tacrolimus

### Approval Criteria

#### Preferred Products: Elidel®, Eucrisa®:

- Age 2 years and older
- Diagnosis of Atopic Dermatitis
- Eucrisa®: Available after trial of topical corticosteroid or Elidel®
  - Limit ONE Tube/28 days

#### Non-Preferred Products: Protopic®, Tacrolimus 0.03%

- Age 2 years and older
- Failure to achieve desired therapeutic outcomes with trial on 1 or more preferred agents
  - Documented trial period for preferred agents
  - Documented ADE/ADR to preferred agents
- Documented compliance on current therapy regimen

#### Dupixent® (Non-Preferred): Initial Criteria (6 month)

- 18 years of age or older AND
- Diagnosis of moderate to severe atopic dermatitis with  $\geq 1$  of the following:
  - Involvement of at least 10% of body surface area (BSA); OR
  - Scoring Atopic Dermatitis (SCORAD) score of 20 or more; OR
  - Investigator's Global Assessment (IGA) with a score  $\geq 3$ ; OR
  - Eczema Area and Severity Index (EASI) score of  $\geq 16$ ; OR
  - Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); AND

**Dupixient® (Non-Preferred): Initial Criteria (continued)**

- Have a prior documented trial and failure (or contraindication) of 1 topical corticosteroids of medium to high potency (e.g., mometasone, fluocinolone) and 1 topical calcineurin inhibitors (tacrolimus or pimecrolimus); AND
- Not have responded adequately (or contraindication) to a 3 month minimum trial of at least 1 immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); AND
- Inadequate response to (or is not a candidate for) a 3 month minimum trial of phototherapy (e.g., psoralens with UVA light [PUVA], UVB, etc) provided patient has reasonable access to photo treatment; AND
- Is not pregnant

**Dupixient® (Non-Preferred): Renewal Criteria**

- Continue to meet above criteria
- Documented response compared to baseline as measured by measures used to qualify moderate to severe AD at baseline (e.g., pruritus, BSA involvement, EASI, IGA, SCORAD)

**Denial Criteria**

- Lack of adequate trial on required preferred agents
- Therapy will be denied if no approval criteria are met
- Drug Prior Authorization Hotline: (800) 392-8030