Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 13, 2025	January 5, 2026	*See below

SUBJECT

Prior Authorization of Dupixent (dupilumab) – Pharmacy Services

BY

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IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Dupixent (dupilumab) submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Dupixent (dupilumab) will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Dupixent (dupilumab) to the appropriate managed care organization.

BACKGROUND:

The Department of Human Services' (Department) Pharmacy and Therapeutics (P&T) Committee reviews published peer-reviewed medical literature and recommends the following:

*01-26-17	09-26-17	27-26-17	33-26-17
02-26-17	11-26-17	30-26-17	
03-26-17	14-26-17	31-26-17	
08-26-17	24-26-17	32-26-17	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html

- Preferred or non-preferred status for new drugs and products in therapeutic classes already included on the Statewide Preferred Drug List (PDL).
- Changes to the statuses of drugs and products on the Statewide PDL from preferred to non-preferred and non-preferred to preferred.
- Therapeutic classes of drugs and products to be added to or deleted from the Statewide PDL.
- New quantity limits.
- New guidelines or revisions to existing guidelines to evaluate the medical necessity of prescriptions submitted for prior authorization.

DISCUSSION:

During the September 25, 2025, meeting, the P&T Committee recommended revisions to the medical necessity guidelines for Dupixent (dupilumab) to clarify the guidelines related to the treatment of atopic dermatitis and add guidelines for the treatment of bullous pemphigoid.

The revisions to the guidelines to determine medical necessity of prescriptions for Dupixent (dupilumab) submitted for prior authorization, as recommended by the P&T Committee, were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Dupixent (dupilumab) are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Dupixent (dupilumab)) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html

I. Requirements for Prior Authorization of Dupixent (dupilumab)

A. Prescriptions That Require Prior Authorization

All prescriptions for Dupixent (dupilumab) must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for Dupixent (dupilumab), the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.); **AND**

5. If currently using a different Monoclonal Antibody (MAB) – Anti-IL, Anti-IgE, Anti-TSLP, will discontinue the other MAB – Anti-IL, Anti-IgE, Anti-TSLP prior to starting Dupixent (dupilumab); **AND**

6. If currently using a different targeted systemic Immunomodulators, Dermatologic (e.g., Adbry [tralokinumab], Cibinqo [abrocitinib], Nemluvio [nemolizumab], Rinvoq [upadacitinib]), will discontinue the other targeted systemic Immunomodulators, Dermatologic prior to starting Dupixent (dupilumab); **AND**

7. For a diagnosis of chronic atopic dermatitis, **both** of the following:

   a. Has atopic dermatitis associated with at least **one** of the following:

      i. A body surface area of 10% or greater that is affected,
      ii. Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp),
      iii. Significant disability or impairment of physical, mental, or psychosocial functioning

   b. Has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

i. **One** of the following:

a) For treatment of the face, skin folds, or other critical areas, a four-week trial of a low-potency topical corticosteroid
b) For treatment of other areas, a four-week trial of a medium-potency or higher topical corticosteroid

ii. An eight-week trial of a topical calcineurin inhibitor;

AND

8. For a diagnosis of asthma, **all** of the following:

a. Has asthma severity consistent with the FDA-approved indication for Dupixent (dupilumab) despite maximal therapeutic doses of or a contraindication or an intolerance to asthma controller drugs based on current national treatment guidelines for the diagnosis and management of asthma,

b. **One** of the following:

i. Has an absolute blood eosinophil count ≥150 cells/microL
ii. Is dependent on oral corticosteroids,

c. Will use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines;

AND

9. For a diagnosis of eosinophilic esophagitis, has a history of therapeutic failure of or a contraindication or an intolerance to a proton pump inhibitor; **AND**

10. For a diagnosis of prurigo nodularis, **both** of the following:

a. Has a history of pruritis lasting at least six weeks

b. Has prurigo nodularis associated with at least **one** of the following:

i. ≥20 nodular lesions
ii. Significant disability or impairment of physical, mental, or psychosocial functioning;

AND

11. For a diagnosis of bullous pemphigoid, **both** of the following:

a. **One** of the following:

   i. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic corticosteroids
   ii. Has corticosteroid-dependent disease

b. **One** of the following:

   i. Has a history of therapeutic failure of a corticosteroid-sparing therapy (e.g., doxycycline, dapsone, methotrexate, mycophenolate, azathioprine)
   ii. Has a contraindication or an intolerance to corticosteroid-sparing therapies;

AND

12. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines; **AND**

13. If a prescription Dupixent (dupilumab) is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. See Quantity Limits List: https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html.

    NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR DUPIXENT (DUPILUMAB): The determination of medical necessity of a request for renewal of a prior authorization for Dupixent (dupilumab) that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Is prescribed Dupixent (dupilumab) by or in consultation with an appropriate specialist (e.g., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.); **AND**

3. Has documented evidence of improvement in disease severity; **AND**

4. For a diagnosis of asthma, **both** of the following:

a. **One** of the following:

   i. Has documented measurable evidence of improvement in the severity of the asthma condition
   ii. Has reduction of oral corticosteroid dose while maintaining asthma control

b. Continues to use Dupixent (dupilumab) in addition to standard asthma controller drugs as recommended by current national treatment guidelines;

AND

5. If a prescription Dupixent (dupilumab) is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. See Quantity Limits List: https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.html.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for Dupixent (dupilumab). If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. References

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