MetroPlus Health

# Policy and Procedure

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|---|---|
| **Title: UM-PT126 Dupixent (dupilumab)** | **Division: Medical Management**<br>**Department: Pharmacy** |
| **Approval Date: 06/24/2025** | **LOB: Medicaid, HIV SNP, HARP, QHP, EP, Gold, GoldCare, CHP** |
| **Effective Date: 06/24/2025** | **Policy Number: UM-PT126** |
| **Review Date: 12/16/2025** | **Cross Reference Number:** |
| **Retired Date:** | **Page 1 of 19** |

## I. POLICY DESCRIPTION:

Dermatologic Agent - Dupixent (dupilumab)

## II. RESPONSIBLE PARTIES:

Medical Management Administration, Pharmacy Department, Utilization Management, Integrated Care Management, Claims Department

## III. DEFINITIONS:

Dupixent indicated for the treatment of adult patients with moderate-to-severe atopic dermatitis whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. Dupixent can be used with or without topical corticosteroids.

Dupixent indicated as an add-on maintenance treatment with topical prescription therapies for patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP).

Dupixent is indicated as an add-on maintenance treatment in patients with moderate-to-severe asthma aged 12 years and older with an eosinophilic phenotype or with oral corticosteroid dependent asthma.

Dupixent is indicated for the treatment of adult patients with prurigo nodularis whose disease is not adequately controlled by topical or systemic therapies or when those therapies are not feasible. Dupixent can be used with or without a topical corticosteroid (TCS) or calcineurin inhibitor (TCI) that is low to medium potency.

Dupixent is indicated for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment.

Dupixent is indicated for the treatment of adult patients with bullous pemphigoid.

Dupixent is a human monoclonal IgG4 antibody that inhibits interleukin-4 (IL-4) and interleukin-13 (IL-13) signaling by specifically binding to the IL-4Rα subunit shared by the IL-4 and IL-13 receptor complexes. Dupixent inhibits IL-4 signaling via the Type I receptor and both IL-4 and IL-13 signaling through the Type II receptor. Blocking IL-4Rα with dupilumab inhibits IL-4 and IL-13 cytokine-induced responses, including the release of proinflammatory cytokines, chemokines and IgE.

## IV. POLICY:

Dupixent will be considered medically necessary once the following coverage criteria is met. Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Chart notes must be submitted to confirm diagnosis and previous treatment(s).

**INITIAL REQUEST:**

**1. Atopic Dermatitis (AD)**

**A.** Member is 6 months of age or older;

**AND**

**B.** Member has a documented diagnosis of moderate-to-severe atopic dermatitis, evaluated using ONE of the following scoring tools:

**a.** Eczema Area Severity Index (EASI) score ≥ 20 at screening and baseline visits;

**OR**

**b.** Investigator's Global Assessment (IGA) score ≥ 3 (on the 0 to 4 IGA scale) at the screening and baseline visits;

**OR**

**c.** Patient-Oriented Eczema Measure (POEM) with a score ≥ 8;

**OR**

**d.** Scoring Atopic Dermatitis (SCORAD) index with a score ≥ 15;

**AND**

**C.** Member has ALL of the following:

**a.** Atopic dermatitis involvement estimated to be ≥ 10% of the body surface area;

**AND**

**b.** Member has had an inadequate response, intolerance, or contraindication to medications in ALL of the following in the past 6 months:

**i.** At least TWO topical corticosteroids in potency categories of Medium-, high- or very high potency for a minimal of 4 weeks of treatment *(See Appendix A)*;

**AND**

**ii.** At least ONE topical calcineurin inhibitor used twice daily for six weeks *(See Appendix B);*

**AND**

**iii.** A topical phosphodiesterase-4 (PDE-4) inhibitor (e.g., Eucrisa (crisaborole)) for a minimal of 4 weeks;

**AND**

**D.** Authorization is for no more than 6 months

2. **Asthma**
   - **A.** Member is 6 years of age or older;

   **AND**
   - **B.** Member has documented diagnosis of moderate to severe asthma as defined by ONE of the following:
     - **a.** Experience's asthma symptoms frequently throughout the day;

     **OR**
     - **b.** Has nighttime awakenings ≥ 7 times per week;

     **OR**
     - **c.** Uses short-acting beta-2-agonist (SABA) for symptom control several times per day;

     **OR**
     - **d.** Symptoms extremely interferes with normal activity;

     **OR**
     - **e.** Lung function is defined as FEV1 < 60% predicted; FEV1/FVC reduced > 5%*;

   **AND**
   - **C.** Member has documented adherence to asthma medications at optimized doses for sufficient treatment length. Medication adherence is defined as > 80% PDC confirmed by paid claim or chart documentation to ONE of the following therapy regimens:
     - **a.** 12 months of high-dose Inhaled corticosteroid (ICS) given in combination with a minimum of 3 months of controller medication (either a long acting beta$_2$-agonist [LABA], or a leukotriene receptor antagonist (LTRA), or sustained-release theophylline), unless the patient is intolerant of or has a known contraindication to these agents;

     **OR**
     - **b.** 6 months of ICS with daily oral glucocorticoids given in combination with a minimum of 3 months of controller medication (either a LABA, or LTRA, or theophylline), unless the patient is intolerant of or has a known contraindication to these agents;

   **AND**
   - **D.** Member has documented lab work of baseline blood eosinophil count of at least 150 cells per microliter;

   **AND**
   - **E.** Authorization is for no more than 6 months

3. **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**
   - **A.** Member is 12 years of age or older;

   **AND**
   - **B.** Member has a documented diagnosis of chronic rhinosinusitis polyposis;

**AND**

**C.** Member has documented recent history (within 6 months) of taking at least THREE of the following topical intranasal agents for at least 3 months: flunisolide, fluticasone, budesonide, triamcinolone acetonide;

**AND**

**D.** Authorization is for no more than 12 months

**4. Eosinophilic Esophagitis (EoE)**

**A.** ONE of the following:

**a.** Member is 1 to 11 years of age or older weighing at least 15kg;

**OR**

**b.** Member is 12 years of age or older weighing at least 40kg;

**AND**

**B.** Member has a documented diagnosis of eosinophilic esophagitis confirmed by esophageal biopsy as characterized by 15 or more intraepithelial esophageal eosinophils per high power field;

**AND**

**C.** Member has history of an average of at least 2 episodes of dysphagia (with intake of solids) per week;

**AND**

**D.** Member has documented recent history (within 6 months) of taking ALL of the following medications unless experiences an inadequate response, intolerance or contraindication:

**a.** Proton pump inhibitor for at least 8 weeks;

**AND**

**b.** Systemic corticosteroid or local therapies (e.g., budesonide, fluticasone) for at least 8 weeks;

**AND**

**E.** Authorization is for no more than 6 months

**5. Prurigo Nodularis (PN)**

**A.** Member is 18 years of age or older;

**AND**

**B.** Member has a documented diagnosis of Prurigo Nodularis (PN) as defined by ALL the following:

**a.** Worst Itch-Numeric Rating Scale (WI-NRS) average score of ≥ 7 in the past week with a minimum number of 4 daily itch scores ranging from 0-10 are required to calculate the average WI-NRS score;

**AND**

**b.** Has a minimum of 20 PN lesions in total on both legs, and/or both arms and/or trunk and these lesions are bilaterally symmetrical on the extremities and must cover at least 2 body surface areas;

**C.** For the management of the immunologic component of PN, the member meets ALL the following:

**a.** Member has tried at least TWO of the following systemic agents and used for a minimal of 4-weeks duration: oral cyclosporine, oral azathioprine, oral methotrexate, oral mycophenolate;

**AND**

**b.** Member has gone through a trial of phototherapy 3 days a week for 3 months or has an intolerability or medical condition that makes phototherapy unfeasible;

**AND**

**c.** Member had an inadequate response, intolerance or contraindication to medications in ALL of the following categories:

**i.** At least TWO topical corticosteroids in potency categories of Medium-, high- or very high potency for a minimal of 4 weeks of treatment *(See Appendix A)*;

**AND**

**ii.** Intralesional corticosteroids to member with <10 lesions;

**AND**

**iii.** At least ONE topical calcineurin inhibitor used twice daily for six weeks *(See Appendix B)*;

**AND**

**D.** For the management of PN with neurologic involvement, member must have tried at least TWO of the following therapies: Topical capsaicin; Gabapentinoids (gabapentin or pregabalin); Antidepressants (paroxetine, duloxetine, amitriptyline, etc.); Antihistamines; aprepitant; naltrexone;

**AND**

**E.** Authorization is for no more than 6 months

**6. Chronic Obstructive Pulmonary Disease (COPD)**

**A.** Member is 18 years of age or older;

**AND**

**B.** Member has a confirmed diagnosis of COPD (i.e., spirometry forced expiratory volume in one second (FEV1)/forced vital capacity (FVC) ratio <0.7) that has been established for more than 12 months;

**AND**

**C.** Member has a Medical Research Council (MRC) Dyspnea Scale grade ≥2;

**AND**

**D.** Member experiences clinical presentation of COPD (i.e., dyspnea, wheezing, chest tightness, fatigue, activity limitation, cough with or without sputum production);

**AND**

**E.** Member has moderate to severe COPD as defined by ONE of the following percent of predicted normal FEV1 per Global Initiative for Chronic Obstructive Lung Disease (GOLD) grade post bronchodilator (i.e., short-acting beta$_2$-agonist (e.g., albuterol), short-acting anticholinergic (e.g., ipratropium) use:

- **a.** GOLD 2 (moderate): 50% ≤ FEV1 < 80% predicted;

**OR**

- **b.** GOLD 3 (severe): 30% ≤ FEV1 < 50% predicted;

**AND**

**F.** ALL of the following:

- **a.** Member has Type 2 (T2) inflammation (i.e., elevated blood eosinophil count ≥ 300 cells/µL);

**AND**

- **b.** Member is currently taking ALL of the following concomitantly for at least 6 months (unless there is a documented contraindication) consecutively and is still experiencing exacerbations [Note: Trelegy is a combination of all 3]:
  - **i.** Long-Acting Beta Agonist (LABA) (e.g., salmeterol, formoterol, olodaterol);

  **AND**

  - **ii.** Long-Acting Muscarinic Antagonists (LAMA) (e.g., tiotropium, umeclidinium);

  **AND**

  - **iii.** Inhaled corticosteroids (ICS) therapy (e.g. fluticasone propionate, budesonide);

**AND**

**G.** Member has a high exacerbation risk as defined by ONE of the following during LABA/LAMA/ICS use:

- **a.** History of 2 or more moderate exacerbations in the past year which required either systemic corticosteroids (intramuscular, intravenous, or oral) and/or antibiotics use;

**OR**

- **b.** History of 1 severe exacerbation in the past year which required hospitalization or observation emergency department/ urgent care facility for more than 24 hours;

**AND**

**H.** Member does not have ANY of the following:

**a.** Current diagnosis of asthma according to the Global Initiative for Asthma (GINA) guidelines, or documented history of asthma;

**OR**

**b.** Significant pulmonary disease other than COPD (e.g., lung fibrosis, sarcoidosis, interstitial lung disease, pulmonary hypertension, bronchiectasis, Churg-Strauss Syndrome etc);

**OR**

**c.** Another diagnosed pulmonary or systemic disease associated with elevated peripheral eosinophil counts;

**OR**

**d.** Cor pulmonale, evidence of right cardiac failure;

**OR**

**e.** Long-term treatment with oxygen >4.0 L/min or if member requires more than 2.0 L/min in order to maintain oxygen saturation >88%;

**OR**

**f.** Hypercapnia requiring Bi-level ventilation;

**OR**

**g.** Respiratory tract infection;

**OR**

**h.** History of, or planned pneumonectomy or lung volume reduction surgery;

**OR**

**i.** Diagnosis of α-1 anti-trypsin deficiency;

**AND**

**I.** Dupixent will be used as add on therapy in combination with LABA + LAMA + ICS therapy (unless there is a documented contraindication);

**AND**

**J.** Authorization is for no more than 6 months

**7. Chronic Spontaneous Urticaria (CSU)**

**A.** Member is 12 years of age or older;

**AND**

**B.** Member has been evaluated for other causes of urticaria, including bradykinin-related angioedema and interleukin-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis);

**AND**

**C.** Member has tried/failed or has history of contradiction or intolerance of ALL of the following regimen for at least 2 months each:

**a.** At least two second generation H1-antihistamines [e.g., Allegra (fexofenadine), Claritin (loratadine), Zyrtec (cetirizine)];

**AND**

**b.** Titrate at least two second generation H1-antihistamine to FOUR times normal dose;
**AND**

**c.** A combination: One second generation H1-antihistamine and One of the following:

i. A Different second generation H1-antihistamine (Titrated to FOUR times the normal dose);
**OR**

ii. A 1 st generation antihistamine to be taken at bedtime;
**OR**

iii. Leukotriene modifier [e.g., Singulair (montelukast)];

**AND**

**D.** Authorization is for no more than 6 months

**8. Bullous Pemphigoid (BP)**

**A.** Member is 18 years of age or older;
**AND**

**B.** Prescribed by or in consultation with a board certified dermatologist;
**AND**

**C.** Member has a confirmed diagnosis of moderate to severe Bullous Pemphigoid as indicated by ALL of the following:

**a.** Clinical features of bullous pemphigoid (e.g., urticarial or eczematous or erythematous plaques, bullae, pruritus);
**AND**

**b.** Baseline Peak Pruritis Numerical Rating Scale (NRS) score for maximum itch intensity ≥ 4;
**AND**

**c.** Bullous Pemphigoid Disease Area Index (BPDAI) activity score ≥ 24;

**AND**

**D.** Member must have tried and failed ALL of the following agents for at least 3 months in the past 12 months unless contraindicated:

**a.** Oral corticosteroids alone or in combination with Chlorambucil;
**AND**

**b.** Topical corticosteroids;
**AND**

**c.** Non-steroid immunosuppressants (e.g, methotrexate, azathioprine, mycophenolate mofetil);
**AND**

**d.** Antibiotics with anti-inflammatory properties (e.g, tetracyclines, sulfonamides, sulfones) alone or in combination with nicotinamide;
**AND**

**e.** Topical calcineurin inhibitor;

**AND**

**E.** Member will receive standard regimen of oral corticosteroids (e.g. prednisone, prednisolone) and taper off the corticosteroid once disease control has occurred unless member is contraindicated;

**AND**

**F.** Member does not have ANY other forms of Pemphigoid other than classic Bullous Pemphigoid (e.g., Brunsting-Perry cicatricial pemphigoid, anti-p200 pemphigoid, epidermolysis bullosa acquisita, or BP with concomitant pemphigus vulgaris);

**AND**

**G.** Authorization is for no more than 6 months;

**RENEWAL REQUEST:**

1. **Atopic Dermatitis (AD)**
   - **A.** Initial conditions of coverage have been met;
   - **AND**
   - **B.** Member has documented improvement of the condition using ONE of the following scoring tools:
     - **a.** IGA reduction from baseline of ≥ 2 points at Week 16;
     - **OR**
     - **b.** EASI reduction from baseline by at least 75%;
     - **OR**
     - **c.** POEM reduction from baseline by at least 3 points;
     - **OR**
     - **d.** SCORAD reduction from baseline by at least 50%;
   - **AND**
   - **C.** Member did not experience ANY of the following adverse effects while on Dupixent:
     - **a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;
     - **OR**
     - **b.** Conjunctivitis and keratitis;
     - **OR**
     - **c.** Arthralgia;
   - **AND**
   - **D.** Authorization is for no more than 12 months

2. **Asthma**
   - **A.** Initial conditions of coverage have been met;

   **AND**
   - **B.** Member has a documented improvement of the condition;

   **AND**
   - **C.** Member did not experience ANY of the following adverse effects while on Dupixent therapy:
     - **a.** Acute asthma symptoms;

     **OR**
     - **b.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;

     **OR**
     - **c.** Conjunctivitis and keratitis;

     **OR**
     - **d.** Arthralgia;

   **AND**
   - **D.** Authorization is for no more than 12 months

3. **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**
   - **A.** All initial conditions of coverage have been met;

   **AND**
   - **B.** Member has a documented improvement of the condition;

   **AND**
   - **C.** Member did not experience ANY of the following adverse effects while on Dupixent:
     - **a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;

     **OR**
     - **b.** Conjunctivitis and keratitis;

     **OR**
     - **c.** Arthralgia;

   **AND**
   - **D.** Authorization is for no more than 12 months

4. **Eosinophilic Esophagitis (EoE)**
   - **A.** All initial conditions of coverage have been met;

   **AND**
   - **B.** Member has achieved or maintained positive clinical response with Dupixent therapy as evidenced by improvement in signs and symptoms of eosinophilic esophagitis (e.g., dysphagia, heartburn, chest pain, emesis);

**C.** Member did not experience ANY of the following adverse effects while on Dupixent:
- **a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;

**OR**
- **b.** Conjunctivitis and keratitis;

**OR**
- **c.** Arthralgia;

**AND**

**D.** Authorization is for no more than 12 months

**5. Prurigo Nodularis (PN)**

**A.** All initial conditions of coverage have been met;

**AND**

**B.** Member has a documented improvement of the condition as evidenced by a reduction in pruritus, nodular lesion size and count and or improvement with PN related assessment scores (e.g., WI-NRS, IGA PN-S);

**C.** Member did not experience ANY of the following adverse effects while on Dupixent:
- **a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;

**OR**
- **b.** Conjunctivitis and keratitis;

**OR**
- **c.** Arthralgia;

**AND**

**D.** Authorization is for no more than 12 months

**6. Chronic Obstructive Pulmonary Disease (COPD)**

**A.** All initial conditions of coverage have been met;

**AND**

**B.** Member has achieved or maintained positive clinical response with Dupixent therapy (i.e., improvement in COPD signs & symptoms, improvement in percent of predicted normal FEV1, reduction in the number of exacerbations, delayed disease progression, improvement in exercise tolerance);

**AND**

**C.** Member did not experience ANY of the following adverse effects while on Dupixent:
- **a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;

**OR**

**b.** Conjunctivitis and keratitis;
**OR**
**c.** Arthralgia;
**AND**
**D.** Authorization is for no more than 12 months

**7. Chronic Spontaneous Urticaria (CSU)**
**A.** Initial conditions of coverage have been met;
**AND**
**B.** Member is 12 years of age or older;
**AND**
**C.** Member achieved or maintained a positive clinical response confirmed by clinical chart notes;
**AND**
**D.** Authorization is for no more than 12 months

**8. Bullous Pemphigoid (BP)**
**A.** All initial conditions of coverage have been met;
**AND**
**B.** Member has achieved or maintained positive clinical response with Dupixent therapy (i.e, improvement in symptoms of Bullous Pemphigoid, a reduction in the frequency or severity of exacerbations, a reduction in dose or completely tapered off oral corticosteroids);
**AND**
**C.** Member did not experience ANY of the following adverse effects while on Dupixent:
**a.** Hypersensitivity reactions, including generalized urticaria and serum sickness or serum sickness-like reactions;
**OR**
**b.** Conjunctivitis and keratitis;
**OR**
**c.** Arthralgia;
**AND**
**D.** Authorization is for no more than 12 months

## V. LIMITATIONS/ EXCLUSIONS:

Dupixent will be considered experimental and investigational if prescribed for indications that have not been approved by the FDA and will not be covered under this policy.

Member does not have known hypersensitivity to Dupixent or any of its excipients.

Member does not have active or current parasitic (Helminth) infections, if member does the treat pre-existing helminth infections before initiating Dupixent. If members become infected while receiving Dupixent and do not respond to anti-helminth treatment, discontinue Dupixent until the infection resolves.

Avoid use of live vaccines during Dupixent therapy.

Dupixent is not to be used for relief of acute bronchospasm.

## VI. APPENDICES:

**APPENDIX A**

| Relative Potency of Selected Topical Corticosteroid | | |
|---|---|---|
| **Drug** | **Dosage Form** | **Strength** |
| **Very High Potency** | | |
| Augmented betamethasone dipropionate | Ointment, Gel | 0.05% |
| Clobetasol propionate | Cream, Ointment | 0.05% |
| Diflorasone diacetate | Ointment | 0.05% |
| Halobetasol propionate | Cream, Ointment | 0.05% |
| **High Potency** | | |
| Amcinonide | Cream, Lotion | 0.1% |
| Augmented betamethasone dipropionate | Cream, Lotion | 0.05% |
| Betamethasone | Cream, Ointment | 0.05% |
| Betamethasone valerate | Ointment | 0.1% |
| Desoximetasone | Cream, Ointment | 0.25% |
| | Gel | 0.05% |
| Diflorasone diacetate | Cream, Ointment | 0.25% |
| | Gel | 0.05% |
| Fluocinonide | Cream, Ointment, Gel | 0.05% |
| Halcinonide | Cream, Ointment | 0.1% |
| Triamcinolone acetonide | Cream, Ointment | 0.5% |
| **Medium Potency** | | |
| Betamethasone | Lotion | 0.05% |
| Betamethasone valerate | Cream | 0.1% |
| Clocortolone pivalate | Cream | 0.1% |
| Desoximetasone | Cream | 0.05% |
| Fluocinolone acetonide | Cream, Ointment | 0.025% |

| | | |
|---|---|---|
| Flurandrenolide | Cream, Ointment | 0.05% |
| | Tape | 4 mg/cm2 |
| Fluticasone propionate | Cream | 0.05% |
| | Ointment | 0.005% |
| Hydrocortisone butyrate | Ointment, Solution | 0.1% |
| Hydrocortisone valerate | Cream, Ointment | 0.2% |
| Mometasone furoate | Cream, Ointment | 0.1% |
| Prednicarbate | Cream, Ointment | 0.1% |
| Triamcinolone acetonide | Cream, Ointment, Lotion | 0.025% |
| | Cream, Ointment, Lotion | 0.1% |

**APPENDIX B:**

| Relative Potency of Topical Calcineurin Inhibitors | | |
|---|---|---|
| **Drug** | **Dosage Form** | **Strength** |
| **Medium Potency** | | |
| Tacrolimus | Ointment | 0.1% |
| **Low Potency** | | |
| Tacrolimus | Ointment | 0.03% |
| Pimecrolimus | Cream | 1% |

## VII. APPLICABLE PROCEDURE CODES:

| CPT | Description |
|---|---|
| C9399 | Unclassified drugs or biologicals |
| J3590 | Unclassified biologics |

## VIII. APPLICABLE DIAGNOSIS CODES:

| CODE | Description |
|---|---|
| J33.0 | Polyp of nasal cavity |
| J33.1 | Polypoid sinus degeneration |
| J33.8 | Other polyp of sinus |
| J33.9 | Nasal polyp, unspecified |
| J44.1 | Chronic obstructive pulmonary disease with (acute) exacerbation |
| J44.9 | Chronic obstructive pulmonary disease, unspecified |
| J82.83 | Eosinophilic asthma |
| K20.0 | Eosinophilic esophagitis |

| | |
|---|---|
| L20.0 | Besnier's prurigo |
| L20.81 | Atopic neurodermatitis |
| L20.82 | Flexural eczema |
| L20.83 | Infantile (acute) (chronic) eczema |
| L20.84 | Intrinsic (allergic) eczema |
| L20.89 | Other atopic dermatitis |
| L20.9 | Atopic dermatitis, unspecified |
| L28.1 | Prurigo nodularis |
| L50.1 | Idiopathic urticaria |
| L50.8 | Other urticaria |
| L12.0 | Bullous pemphigoid |

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| **Title: UM-PT126 Dupixent (dupilumab)** | **Division: Medical Management**<br>**Department: Pharmacy** |
| **Approval Date: 06/24/2025** | **LOB: Medicaid, HIV SNP, HARP, QHP, EP, Gold, GoldCare, CHP** |
| **Effective Date: 06/24/2025** | **Policy Number: UM-PT126** |
| **Review Date: 12/16/2025** | **Cross Reference Number:** |
| **Retired Date:** | **Page 18 of 19** |

**REVISION LOG:**

| REVISIONS | INITIAL | DATE |
|---|---|---|
| Creation date | XZ | 06/24/2025 |
| Update | XZ | 12/16/2025 |

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| **Approved:** **Date:**<br>Suzana Patel 2/18/2026<br>**Suzana Patel, PharmD**<br>**Senior Director of Pharmacy** | **Approved:** **Date:**<br>02.18.2026<br>**Sanjiv Shah, MD**<br>**Chief Medical Officer** |

**Medical Guideline Disclaimer:**

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus HealthPlan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.