

## Clinical Policy: Dupilumab (Dupixent)

Reference Number: CP.PHAR.336

Effective Date: 05.01.17

Last Review Date: 11.19

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Dupilumab (Dupixent<sup>®</sup>) is an interleukin-4 receptor alpha antagonist.

### FDA Approved Indication(s)

Dupilumab is indicated:

- For the treatment of patients aged 12 years and older 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
- 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
- As an add-on maintenance treatment in adult patients with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP)

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Dupixent is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Atopic Dermatitis (must meet all):

1. Diagnosis of atopic dermatitis;
2. Prescribed by or in consultation with a dermatologist or allergist;
3. Age  $\geq$  12 years;
4. Failure of all of the following (a, b, and c), unless contraindicated or clinically significant adverse effects are experienced:
  - a. Two formulary medium to very high potency topical corticosteroids, each used for  $\geq$  2 weeks;
  - b. One non-steroidal topical therapy\*: topical calcineurin inhibitor (e.g., tacrolimus 0.03% ointment and pimecrolimus 1% cream) or Eucrisa<sup>®</sup>, each used for  $\geq$  4 weeks;  
*\* These agents may require prior authorization*
  - c. One or more of the following systemic agents: corticosteroids, azathioprine, methotrexate, mycophenolate mofetil, or cyclosporine;
5. Dose does not exceed the following (a or b):

- a. Initial (one-time) dose: 600 mg;
- b. Maintenance dose: 300 mg every other week.

**Approval duration: 6 months**

**B. Asthma (must meet all):**

1. Diagnosis of asthma and one of the following (a or b):
  - a. Absolute blood eosinophil count  $\geq 150$  cells/mcL within the past 3 months;
  - b. Currently receiving maintenance treatment with systemic glucocorticoids and has received treatment for at least 4 weeks;
2. Prescribed by or in consultation with a/an allergist, immunologist, or pulmonologist;
3. Age  $\geq 12$  years;
4. Member has experienced  $\geq 2$  exacerbations within the last 12 months, requiring any of the following despite adherent use of controller therapy (i.e., moderate- to high-dose inhaled corticosteroid (ICS) plus either a long-acting beta<sub>2</sub> agonist (LABA) or leukotriene modifier (LTRA) if LABA contraindication/intolerance):
  - a. Oral/systemic corticosteroid treatment (or increase in dose if already on oral corticosteroid);
  - b. Urgent care visit or hospital admission;
  - c. Intubation;
5. Dupixent is prescribed concomitantly with an ICS plus either a LABA or LTRA;
6. Dupixent will not be used concomitantly with Cinqair<sup>®</sup>, Fasentra<sup>®</sup>, Nucala<sup>®</sup>, or Xolair<sup>®</sup>;
7. Dose does not exceed the following (a or b):
  - a. Initial (one-time) dose: 600 mg;
  - b. Maintenance dose: 300 mg every other week.

**Approval duration: 6 months**

**C. Chronic Rhinosinusitis with Nasal Polyposis (must meet all):**

1. Diagnosis of CRSwNP with documentation of all of the following (a, b, and c):
  - a. Presence of nasal polyps;
  - b. Disease is bilateral;
  - c. Member has experienced signs and symptoms (e.g., nasal congestion/blockage/obstruction, loss of smell, rhinorrhea) for  $\geq 12$  weeks;
2. Prescribed by or in consultation with an allergist, immunologist, or otolaryngologist;
3. Age  $\geq 18$  years;
4. Member has required the use of systemic corticosteroids for symptom control within the last 2 years, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B for examples*);
5. Member has failed maintenance therapy with at least two intranasal corticosteroids, each used for  $\geq 8$  weeks, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B for examples*);
6. Dupixent is prescribed concomitantly with an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B for examples*);
7. Dose does not exceed 300 mg every other week.

**Approval duration: 6 months**

**D. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Atopic Dermatitis (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by, including but not limited to, reduction in itching and scratching;
3. If request is for a dose increase, new dose does not exceed 300 mg given every other week.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to the member’s renewal date, whichever is longer

**B. Asthma (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Demonstrated adherence to asthma controller therapy that includes an ICS plus either a LABA or LTRA;
3. Member is responding positively to therapy (*see Appendix D*);
4. If request is for a dose increase, new dose does not exceed 300 mg every other week.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to the member’s renewal date, whichever is longer

**C. Chronic Rhinosinusitis with Nasal Polyposis (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Demonstrated adherence to an intranasal corticosteroid, unless contraindicated or clinically significant adverse effects are experienced;
3. Member is responding positively to therapy (*see Appendix D*);
4. If request is for a dose increase, new dose does not exceed 300 mg every other week.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to the member’s renewal date, whichever is longer

**D. Other diagnoses/indications (must meet 1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less); or**

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

CRSwNP: chronic rhinosinusitis with nasal polyposis

FDA: Food and Drug Administration

ICS: inhaled corticosteroid

LABA: long-acting beta<sub>2</sub> agonist

LTRA: leukotriene modifier

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>ATOPIC DERMATITIS</b>		
<b>Very High Potency Topical Corticosteroids</b>		
augmented betamethasone 0.05% (Diprolene <sup>®</sup> AF) cream, ointment, gel, lotion	Apply topically to the affected area(s) BID	varies
clobetasol propionate 0.05% (Temovate <sup>®</sup> ) cream, ointment, gel, solution		
diflorasone diacetate 0.05% (Maxiflor <sup>®</sup> , Psorcon E <sup>®</sup> ) cream, ointment		
halobetasol propionate 0.05% (Ultravate <sup>®</sup> ) cream, ointment		
<b>High Potency Topical Corticosteroids</b>		
augmented betamethasone 0.05% (Diprolene <sup>®</sup> AF) cream, ointment, gel, lotion	Apply topically to the affected area(s) BID	varies
diflorasone 0.05% (Florone <sup>®</sup> , Florone E <sup>®</sup> , Maxiflor <sup>®</sup> , Psorcon E <sup>®</sup> ) cream		

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
fluocinonide acetone 0.05% (Lidex <sup>®</sup> , Lidex E <sup>®</sup> ) cream, ointment, gel, solution		
triamcinolone acetone 0.5% (Aristocort <sup>®</sup> , Kenalog <sup>®</sup> ) cream, ointment		
<b>Medium Potency Topical Corticosteroids</b>		
desoximetasone 0.05% (Topicort <sup>®</sup> ) cream, ointment, gel	Apply topically to the affected area(s) BID	varies
fluocinolone acetone 0.025% (Synalar <sup>®</sup> ) cream, ointment		
mometasone 0.1% (Elocon <sup>®</sup> ) cream, ointment, lotion		
triamcinolone acetone 0.025%, 0.1% (Aristocort <sup>®</sup> , Kenalog <sup>®</sup> ) cream, ointment		
<b>Low Potency Topical Corticosteroids</b>		
alclometasone 0.05% (Aclovate <sup>®</sup> ) cream, ointment	Apply topically to the affected area(s) BID	varies
desonide 0.05% (Desowen <sup>®</sup> ) cream, ointment, lotion		
fluocinolone acetone 0.01% (Synalar <sup>®</sup> ) solution		
hydrocortisone 2.5% (Hytone <sup>®</sup> ) cream, ointment		
<b>Other Classes of Agents</b>		
Protopic <sup>®</sup> (tacrolimus), Elidel <sup>®</sup> (pimecrolimus)	Children ≥ 2 years and adults: Apply a thin layer topically to affected skin BID. Treatment should be discontinued if resolution of disease occurs.	varies
Eucrisa <sup>®</sup> (crisaborole)	Apply to the affected areas BID	varies
cyclosporine	3-6mg/kg/day PO BID	300 mg/day
azathioprine	1-3mg/kg/day PO once daily	Weight-based
methotrexate	7.5-25mg/wk PO once weekly	25 mg/week
mycophenolate mofetil	1-1.5 PO BID	3 g/day
Systemic corticosteroids (e.g. prednisone, prednisolone, triamcinolone)	PO, IM, or parenteral; dose varies	varies
<b>ASTHMA</b>		
<b>ICS (medium – high dose)</b>		
Qvar <sup>®</sup> (beclomethasone)	> 200 mcg/day	4 actuations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	40 mcg, 80 mcg per actuation 1-4 actuations BID	
budesonide (Pulmicort®)	> 400 mcg/day 90 mcg, 180 mcg per actuation 2-4 actuations BID	2 actuations BID
Alvesco® (ciclesonide)	> 160 mcg/day 80 mcg, 160 mcg per actuation 1-2 actuations BID	2 actuations BID
Aerospan® (flunisolide)	> 320 mcg/day 80 mcg per actuation 2-4 actuations BID	2 actuations BID
Flovent® (fluticasone propionate)	> 250 mcg/day 44-250 mcg per actuation 2-4 actuations BID	2 actuations BID
Arnuity Ellipta® (fluticasone furoate)	200 mcg/day 100 mcg, 200 mcg per actuation 1 actuation QD	1 actuation QD
Asmanex® (mometasone)	>220 mcg/day HFA: 100 mcg, 200 mcg per actuation Twisthaler: 110 mcg, 220 mcg per actuation 1-2 actuations QD to BID	2 inhalations BID
<b>LABA</b>		
Serevent® (salmeterol)	50 mcg per dose 1 inhalation BID	1 inhalation BID
<b>Combination products (ICS + LABA)</b>		
Dulera® (mometasone/formoterol)	100/5 mcg, 200/5 mcg per actuation 2 actuations BID	4 actuations per day
Breo Ellipta® (fluticasone/vilanterol)	100/25 mcg, 200/25 mcg per actuation 1 actuation QD	1 actuation QD
Advair® (fluticasone/ salmeterol)	Diskus: 100/50 mcg, 250/50 mcg, 500/50 mcg per actuation HFA: 45/21 mcg, 115/21 mcg, 230/21 mcg per actuation 1 actuation BID	1 actuation BID
fluticasone/salmeterol (Airduo RespiClick®)	55/13 mcg, 113/14 mcg, 232/14 mcg per actuation 1 actuation BID	1 actuation BID
Symbicort® (budesonide/formoterol)	80 mcg/4.5 mcg, 160 mcg/4.5 mcg per actuation 2 actuations BID	2 actuations BID

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>LTRA</b>		
montelukast (Singulair <sup>®</sup> )	4 to 10 mg PO QD	10 mg per day
zafirlukast (Accolate <sup>®</sup> )	10 to 20 mg PO BID	40 mg per day
zileuton ER (Zyflo <sup>®</sup> CR)	1200 mg PO BID	2400 mg per day
Zyflo <sup>®</sup> (zileuton)	600 mg PO QID	2400 mg per day
<b>Oral corticosteroids</b>		
dexamethasone (Decadron <sup>®</sup> )	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred <sup>®</sup> , Orapred ODT <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone <sup>®</sup> )	40 to 80 mg PO in 1 to 2 divided doses	Varies
<b>CRSwNP</b>		
<b>Intranasal corticosteroids</b>		
beclomethasone (Beconase AQ <sup>®</sup> , Qnasl <sup>®</sup> )	1-2 sprays IN BID	2 sprays/nostril BID
budesonide (Rhinocort <sup>®</sup> Aqua, Rhinocort <sup>®</sup> )	128 mcg IN QD or 200 mcg IN BID	1-2 inhalations/nostril/day
flunisolide	2 sprays IN BID	2 sprays/nostril TID
fluticasone propionate (Flonase <sup>®</sup> )	1-2 sprays IN BID	2 sprays/nostril BID
mometasone (Nasonex <sup>®</sup> )	2 sprays IN BID	2 sprays/nostril BID
Omnanis <sup>®</sup> , Zetonna <sup>®</sup> (ciclesonide)	Omnanis: 2 sprays IN QD Zetonna: 1 spray IN QD	Omnanis: 2 sprays/nostril/day Zetonna: 2 sprays/nostril/day
triamcinolone (Nasacort <sup>®</sup> )	2 sprays IN QD	2 sprays/ nostril/day
<b>Oral corticosteroids</b>		
dexamethasone (Decadron <sup>®</sup> )	0.75 to 9 mg/day PO in 2 to 4 divided doses	Varies
methylprednisolone (Medrol <sup>®</sup> )	4 to 48 mg PO in 1 to 2 divided doses	Varies
prednisolone (Millipred <sup>®</sup> , Orapred ODT <sup>®</sup> )	5 to 60 mg PO in 1 to 2 divided doses	Varies
prednisone (Deltasone <sup>®</sup> )	5 to 60 mg PO in 1 to 2 divided doses	Varies

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): known hypersensitivity to Dupixent or any of its excipients



- Boxed warning(s): none reported

*Appendix D: General Information*

- The Phase III pivotal studies (SOLO 1 and SOLO 2) of Dupixent showed no significant difference in clinical outcomes between dosing of Dupixent every week and every other week for the treatment of atopic dermatitis.
- During clinical trials (LIBERTY ASTHMA QUEST), among patients with a baseline blood eosinophil count of < 150 per cubic millimeter, the exacerbation rate was similar with dupilumab and with placebo: 0.47 (95% CI, 0.36 to 0.62) with lower-dose dupilumab and 0.51 (95% CI, 0.35 to 0.76) with matched placebo, and 0.74 (95% CI, 0.58 to 0.95) with higher-dose dupilumab and 0.64 (95% CI, 0.44 to 0.93) with matched placebo.
- Positive response to therapy for asthma may include reduction in exacerbations or corticosteroid dose, improvement in forced expiratory volume over one second since baseline, or reduction in the use of rescue therapy.
- Lab results for blood eosinophil counts can be converted into cells/mcL using the following unit conversion calculator: <https://www.fasenrahcp.com/m/fasenra-eosinophil-calculator.html>
- Positive response to therapy for CRSwNP may include reduced nasal polyp size, reduced need for systemic corticosteroids, improved sense of smell, or improved quality of life.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Moderate-to-severe atopic dermatitis	Adults: Initial dose of 600 mg SC followed by 300 mg SC every other week  Adolescents 12-17 years of age: Body weight < 60 kg: Initial dose of 400 mg SC followed by 200 mg SC every other week Body weight ≥ 60 kg: Initial dose of 600 mg SC followed by 300 mg SC every other week	600 mg initially, then 300 mg every other week
Moderate-to-severe asthma	Initial dose of 400 mg SC followed by 200 mg SC every other week; or Initial dose of 600 mg SC followed by 300 mg SC every other week  For patients requiring concomitant oral corticosteroids or with co-morbid moderate-to-severe atopic dermatitis for which Dupixent is indicated, start with an initial dose of 600 mg SC followed by 300 mg SC every other week	300 mg every other week
CRSwNP	300 mg SC every other week	300 mg every other week

**VI. Product Availability**

Pre-filled syringe with needle shield for injection: 200 mg/1.14 mL, 300 mg/2 mL



## VII. References

1. Dupixent Prescribing Information. Tarrytown, NY: Regeneron Pharmaceuticals, Inc.; June 2019. Available at: [www.dupixent.com](http://www.dupixent.com). Accessed July 10, 2019.
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4. Eichenfield F, Tom WL, Chamlin SL, et al. Guidelines of Care for the Management of Atopic Dermatitis. *J Am Acad Dermatol*. 2014 February; 70(2): 338–351.
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7. Global Initiative for Asthma: Global strategy for asthma management and prevention (2018 update). Available at: <https://ginasthma.org/2018-gina-report-global-strategy-for-asthma-management-and-prevention/>. Accessed November 13, 2018.
8. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): adult sinusitis. *Otolaryngology–Head and Neck Surgery* 2015, Vol. 152(2S) S1–S39.
9. Peters AT, Spector S, Hsu J, et al. Diagnosis and management of rhinosinusitis: a practice parameter update. *Ann Allergy Asthma Immunol* 2014. 113:347-85.
10. Fokkens WJ, Lund V, Bachert C, et al. EUFOREA consensus on biologics for CRSwNP with or without asthma. doi: 10.1111/all.13875.

## Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
C9399; J3590	Unclassified drugs or biologicals

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy	04.17	05.17
1Q18 annual review: policies combined for HIM, Medicaid and commercial; no significant changes; references were reviewed and updated.	11.15.17	02.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2019 annual review: criteria added for new FDA indication: moderate-to-severe asthma; references reviewed and updated.	12.04.18	02.19
Increased initial approval duration of AD from 16 weeks to 6 months; clarified positive response to therapy examples.	02.19.19	05.19
Updated atopic dermatitis with new FDA-approved age extension to patients 12 years of age and older; references reviewed and updated.	03.21.19	
Criteria added for new FDA indication: CRSwNP; added allergists as potential prescribers for atopic dermatitis; references reviewed and updated.	08.06.19	11.19

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy; HIM.PA.103.

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