DUPIXENT®
(dupilumab) Injection
200mg · 300mg

The first and only FDA-approved treatment for EoE patients as young as 1 year, weighing ≥15 kg

ARE YOUR EoE PATIENTS UNCONTROLLED DESPITE PPI THERAPY?

MY EoE HASN'T BEEN AS BAD, SO I TRY NOT TO COMPLAIN.
I'M FINE.
George

WE CAN DO MORE THAN FINE.

Not an actual patient.

CURRENT CONCERNS

- Taking high-dose PPI for the past three months
- Histologic findings reveal 67 EOS/HPF
- Reports that symptoms are less severe but still occur
- Most recent endoscopy showed furrows, edema, and rings

~55% of patients ***failed to achieve histologic response on PPIs***[1,a]

IMPORTANT SAFETY INFORMATION

CONTRAINDICATION: DUPIXENT is contraindicated in patients with known hypersensitivity to dupilumab or any of its excipients.

[a] Based on a meta-analysis of 73 studies comprising 7304 patients with EoE. Histologic response is defined as <15 EOS/HPF.[1]
EoE, eosinophilic esophagitis; EOS/HPF, eosinophils per high-power field; PPI, proton pump inhibitor.

Please see additional Important Safety Information throughout and accompanying full Prescribing Information here.

IN PATIENTS 12+ YEARS

HISTOLOGIC REMISSION ACHIEVED WITH DUPIXENT[2,3]

HISTOLOGIC REMISSION
(≤6 EOS/HPF peak esophageal intraepithelial EOS count)

Week 24: *Part B Coprimary Endpoint*

59% of patients with DUPIXENT (n=80)

VS

6% with placebo (n=79)

Week 52: *Part B-C Secondary Endpoint*

85% of patients with DUPIXENT (n=74)

VS

68% of patients after switching to DUPIXENT (n=37)

- **Week 24 (Part A) Coprimary Endpoint: 60% of patients** with DUPIXENT (n=42) vs **5%** with placebo (n=39) (*P*<0.0001)
- **Week 52 (Part A-C) Secondary Endpoint: 56% of patients** after 52 weeks of treatment with DUPIXENT (n=34) and **60%** after switching to DUPIXENT from placebo at Week 24 (n=30)

HISTOLOGIC RESPONSE
(<15 EOS/HPF peak esophageal intraepithelial EOS count)

Week 24: *Part B Secondary Endpoint*

83% of patients with DUPIXENT (n=80)

VS

8% with placebo (n=79)

Week 52: *Part B-C Secondary Endpoint*

100% of patients with DUPIXENT (n=74)

VS

78% of patients after switching to DUPIXENT (n=37)

- **Week 24 (Part A) Secondary Endpoint: 64% of patients** with DUPIXENT (n=42) vs **8%** with placebo (n=39)
- **Week 52 (Part A-C) Secondary Endpoint: 82% of patients** after 52 weeks of treatment with DUPIXENT (n=34) and **70%** after switching to DUPIXENT from placebo at Week 24 (n=30)

In Part B, histologic response was ordered after the point at which hierarchical testing procedure failed.

Results for histologic remission and histologic response are descriptive in the extended active treatment period at Week 52. Definitive conclusions cannot be made due to limitations associated with extended active treatment design, including lack of comparator arm and decreasing sample size.

Please see Study Design on page 6.

IN PATIENTS 12+ YEARS

LONG-TERM REDUCTION IN THE FREQUENCY AND SEVERITY OF DYSPHAGIA[2,3,a,b]

DYSPHAGIA SYMPTOM QUESTIONNAIRE (DSQ) TOTAL SCORE

Week 24: *Part B Coprimary Endpoint*

64% reduction (-23.8 points) with DUPIXENT (n=80)

VS

41% reduction (-13.9 points) with placebo (n=79)

Week 52: *Part B-C Secondary Endpoint*

81% reduction (-30.3 points) with DUPIXENT (n=54)

VS

78% reduction (-27.3 points) after switching to DUPIXENT (n=24)

Part A (Coprimary Endpoint at Week 24)

- **Week 4[a]: 9-point reduction (28%)** from baseline with DUPIXENT (n=42) vs **4-point reduction (11%)** with placebo (n=39)
- **Week 24: 21.9-point reduction (69%)** from baseline with DUPIXENT (n=42) vs **9.6-point reduction (32%)** with placebo (n=39) (*P*<0.001)

Part A-C (Secondary Endpoint)

- **Week 52: 23.4-point reduction (76%)** from baseline after 52 weeks of treatment with DUPIXENT (n=29)
- **Week 52: 21.7-point reduction (66%)** from baseline after switching to DUPIXENT from placebo at Week 24 (n=23)

Results are descriptive in the extended active treatment period at Week 52. Definitive conclusions cannot be made due to limitations associated with extended active treatment design, including lack of comparator arm and decreasing sample size.

[a] **Week 4 assessment is a post hoc analysis; results are descriptive.**

[b] Total biweekly DSQ scores range from 0 to 84; higher scores indicate greater frequency and severity of dysphagia.

EOS, eosinophil.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS

Hypersensitivity: Hypersensitivity reactions, including anaphylaxis, serum sickness or serum sickness-like reactions, angioedema, generalized urticaria, rash, erythema nodosum, and erythema multiforme have been reported. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT.

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IN PATIENTS 12+ YEARS

VISIBLE REDUCTION IN INFLAMMATORY AND FIBROTIC FEATURES IN THE ESOPHAGUS[3]

REDUCTION IN EREFS TOTAL SCORE

Week 24: *Part B Secondary Endpoint*

66% reduction (-4.5 points) with DUPIXENT (n=80)

VS

8% (-0.6 points) with placebo (n=79)

Week 52: *Part B-C Secondary Endpoint*

77% reduction (-5.3 points) with DUPIXENT (n=63)

VS

76% (-6.1 points) after switching to DUPIXENT (n=37)

Part A

- **Week 24: 3.2-point reduction (49%)** from baseline with DUPIXENT (n=42) vs **0.3-point reduction (5%)** with placebo (n=39)

Part A-C

- **Week 52: 4.1-point reduction (63%)** from baseline after 52 weeks of treatment with DUPIXENT (n=35)
- **Week 52: 3.9-point reduction (65%)** from baseline after switching to DUPIXENT from placebo at Week 24 (n=30)

Thresholds for clinically meaningful changes in EREFS scores have not been established. Additionally, in Part B, this endpoint was ordered after the point at which hierarchical testing procedure failed.

Results are descriptive in the extended active treatment period at Week 52. Definitive conclusions cannot be made due to limitations associated with extended active treatment design, including lack of comparator arm and decreasing sample size.

Please see Study Design on page 6.

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

Risk Associated with Abrupt Reduction of Corticosteroid Dosage: Do not discontinue systemic, topical, or inhaled corticosteroids abruptly upon initiation of DUPIXENT. Reductions in corticosteroid dose, if appropriate, should be gradual and performed under the direct supervision of a healthcare provider. Reduction in corticosteroid dose may be associated with systemic withdrawal symptoms and/or unmask conditions previously suppressed by systemic corticosteroid therapy.
Patients with Co-morbid Asthma: Advise patients with co-morbid asthma not to adjust or stop their asthma treatments without consultation with their physicians.
Arthralgia and Psoriatic Arthritis: Arthralgia has been reported with the use of DUPIXENT with some patients reporting gait disturbances or decreased mobility associated with joint symptoms; some cases resulted in hospitalization. Cases of new-onset psoriatic arthritis requiring systemic treatment have been reported with the use of DUPIXENT. Advise patients to report new-onset or worsening joint symptoms. If symptoms persist or worsen, consider rheumatological evaluation and/or discontinuation of DUPIXENT.

IN PATIENTS 12+ YEARS

DUPIXENT HAS A DEMONSTRATED SAFETY PROFILE[2]

ADVERSE REACTIONS OCCURRING IN ≥2% OF PATIENTS 12+ YEARS WITH EoE TREATED WITH DUPIXENT 300 mg QW IN PARTS A AND B AND GREATER THAN PLACEBO (24-WEEK SAFETY POOL)[2]

	DUPIXENT 300 mg QW (n=122) | n (%)	Placebo QW (n=117) | n (%)
Injection site reactions[a]	46 (38%)	39 (33%)
Upper respiratory tract infections[b]	22 (18%)	12 (10%)
Arthralgia	3 (2%)	1 (1%)
Herpes viral infections[c]	3 (2%)	1 (1%)

[a] Injection site reactions include, but are not limited to, injection site swelling, pain, and bruising.[2]
[b] Upper respiratory tract infections are composed of several terms including, but not limited to, COVID-19, sinusitis, and upper respiratory tract infection.[2]
[c] Herpes viral infections are composed of oral herpes and herpes simplex.[2]

In Parts A and B, the safety profile of DUPIXENT was similar between adults and 72 pediatric subjects aged 12 to 17 years, weighing ≥40 kg.[2]

During Part A-C, the most frequently reported TEAEs (in ≥5% of participants overall) were: injection site reaction (15.6%), injection site erythema (11.7%), injection site pain (6.5%), headache (6.5%), nasopharyngitis (5.2%), acne (5.2%), and insomnia (5.2%).[3]

During Part B-C, the most frequently reported TEAEs (in ≥5% of participants overall) were: injection site reaction (13.7%), injection site pain (8.4%), injection site erythema (6.6%), and COVID-19 (7.9%).[3]

IMPORTANT SAFETY INFORMATION

WARNINGS AND PRECAUTIONS (cont'd)

Parasitic (Helminth) Infections: It is unknown if DUPIXENT will influence the immune response against helminth infections. Treat patients with pre-existing helminth infections before initiating therapy with DUPIXENT. If patients become infected while receiving treatment with DUPIXENT and do not respond to anti-helminth treatment, discontinue treatment with DUPIXENT until the infection resolves.
Vaccinations: Consider completing all age-appropriate vaccinations as recommended by current immunization guidelines prior to initiating DUPIXENT. Avoid use of live vaccines during treatment with DUPIXENT.
ADVERSE REACTIONS: The most common adverse reactions (incidence ≥2%) in patients with EoE are injection site reactions, upper respiratory tract infections, arthralgia, and herpes viral infections.

EREFS, endoscopic reference score; QW, once weekly;
TEAE, treatment-emergent adverse event.

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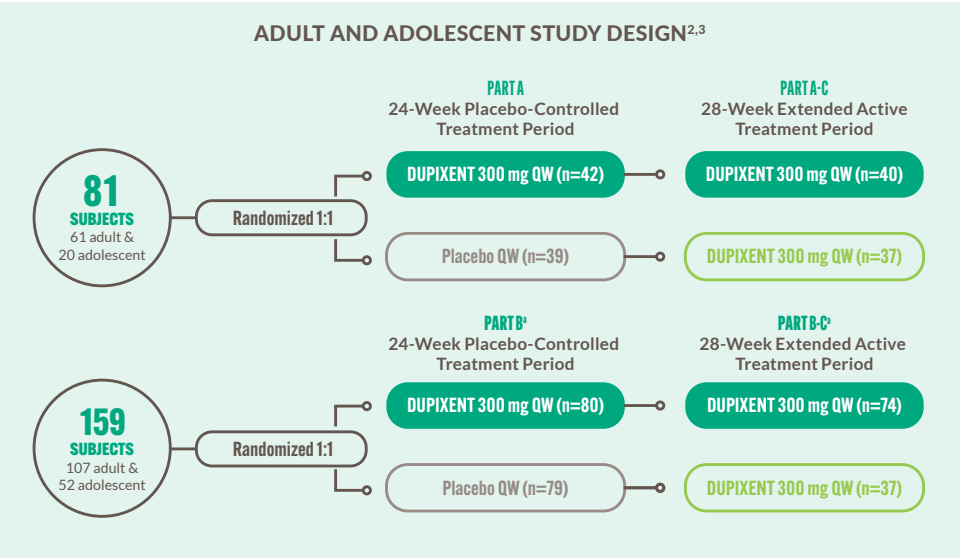
DUPIXENT WAS STUDIED IN ADULTS AND ADOLESCENTS WITH EoE IN A MULTIPART PHASE 3 CLINICAL TRIAL[2,3]

ADOLESCENTS ≥12 YEARS WITH UNCONTROLLED EoE, DESPITE PPI USE, FOR UP TO 52 WEEKS



Parts A and B

- Two 24-week, double-blind, placebo-controlled trials. Subjects were randomized to receive either DUPIXENT 300 mg QW, DUPIXENT 300 mg Q2W (Parts B and B-C only), or placebo QW[a]

Part C

- A 28-week active treatment extension study, for a total of 52 weeks of treatment in subjects who were treated with DUPIXENT 300 mg or placebo, completing Parts A or B

Eligibility Criteria

All enrolled subjects (81 in Part A and 159 in Part B) were required to have:

- Uncontrolled EoE as defined by:
  - ≥15 intraepithelial EOS/HPF despite 8-week course of a high-dose PPI
  - EoE symptoms (DSQ score ≥10)

[a] DUPIXENT 300 mg Q2W was studied in Part B (n=81) and Part B-C (n=116) but is not approved for the treatment of EoE.[3] Q2W, once every two weeks.

IMPORTANT SAFETY INFORMATION

USE IN SPECIFIC POPULATIONS

- **Pregnancy:** A pregnancy exposure registry monitors pregnancy outcomes in women exposed to DUPIXENT during pregnancy. Available data from case reports and case series with DUPIXENT use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage or adverse maternal or fetal outcomes. Human IgG antibodies are known to cross the placental barrier; therefore, DUPIXENT may be transmitted from the mother to the developing fetus.
- **Lactation:** There are no data on the presence of DUPIXENT in human milk, the effects on the breastfed infant, or the effects on milk production. Maternal IgG is known to be present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for DUPIXENT and any potential adverse effects on the breastfed child from DUPIXENT or from the underlying maternal condition.

DUPIXENT ATTRIBUTES AND CONSIDERATIONS[2]

NO BOXED WARNING

Please see additional Warnings and Precautions in the Prescribing Information and Important Safety Information throughout.

NO KNOWN DRUG-TO-DRUG INTERACTIONS

Not metabolized through the liver or excreted through the kidneys.

DUPIXENT IS NOT AN IMMUNOSUPPRESSANT

NO REQUIREMENT FOR INITIAL LAB TESTING OR ONGOING LAB MONITORING

according to the Prescribing Information.


Not an actual patient.

IMPORTANT SAFETY INFORMATION

SELECT WARNING AND PRECAUTION

Hypersensitivity: Hypersensitivity reactions, including anaphylaxis, serum sickness or serum sickness-like reactions, angioedema, generalized urticaria, rash, erythema nodosum, and erythema multiforme have been reported. If a clinically significant hypersensitivity reaction occurs, institute appropriate therapy and discontinue DUPIXENT.

References: 1. Lucendo AJ, Gutiérrez-Ramirez L, Tejera-Munoz A, Molina-Infante J, Arias Á; EUREOS Guidelines Committee. Proton pump inhibitors for inducing and maintaining remission in eosinophilic esophagitis: an updated systematic review and meta-analysis. *Clin Gastroenterol Hepatol.* 2025;23(12):2115-2127.e21. doi:10.1016/j.cgh.2025.01.016 **2.** DUPIXENT Prescribing Information. **3.** Data on file, Regeneron Pharmaceuticals, Inc. **4.** Dellon ES, Rothenberg ME, Collins MH, et al. Dupilumab in adults and adolescents with eosinophilic esophagitis. *N Engl J Med.* 2022;387(25):2317-2330. **5.** Chehade M, Dellon ES, Spergel JM, et al. Dupilumab for eosinophilic esophagitis in patients 1 to 11 years of age. *N Engl J Med.* 2024;390(24):2239-2251. **6.** Data on file, 2025. IQVIA Sanofi. **7.** Data on file. DUPIXENT EoE 2025 Payer Coverage Tracker.

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WE CAN DO MORE THAN FINE.

LONG-TERM RESULTS IN THREE KEY PILLARS OF EoE MANAGEMENT[2,4,5]:

Histology

Symptoms

Endoscopic features

Demonstrated safety profile in patients as young as 1 year with EoE[2,5]

The most common adverse reactions were injection site reactions.[2,5]

DUPIXENT is not an immunosuppressant[2]

OVER **69,000** EoE patients treated since approval in 2022[6,a]

81% of commercially insured patients nationally **have coverage for DUPIXENT without requirements for trial of swallowed topical corticosteroids (STC)**[7,b,c]

[a] IQVIA National Source of Business (NSOB) data as of December 2025.[6]
[b] MMIT Analysis as of August 2025.
[c] Coverage varies by type and plan.

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