Pharmacy Drug Policy Checklist

POLICY NAME	Benlysta (belimumab)	POLICY #	

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **4.1** Treatment of severe active central nervous system lupus are considered experimental at this time due to a lack of studies which show efficacy
- ☐ **4.2** When used in conjunction with biologic agents or intravenous cyclophosphamide
- ☐ **4.3** Benlysta will not be covered if used in combination with Saphnelo or Lupkynis CPT Codes HCPCS Codes J0490 Injection, belimumab, 10 mg (Benlysta)

Criteria for Coverage for Systemic Lupus Erythematosus (SLE)

- ☐ **1.1** Diagnosis of active SLE including hematologic disease
- ☐ **1.2** Age 5 years or older
- ☐ **1.3** Prescribed by or in consultation with a rheumatologist (musculoskeletal doctor)
- ☐ **1.4** Documented compliance with hydroxychloroquine or chloroquine, unless contraindicated
  - Compliance defined as possession of 150 days-worth of drug in 6 months
- ☐ **1.5** Documented failure/intolerance/contraindication to treatment with at least one other standard therapy such as prednisone, azathioprine, leflunomide, methotrexate, mycophenolate, NSAIDs

Criteria for Coverage for Lupus Nephritis

- ☐ **2.1** Diagnosis of active lupus nephritis with an eGFR ≥ 45mL/min/1.73m2
- ☐ **2.2** Age 5 years or older
- ☐ **2.3** Prescribed by or in consultation with a nephrologist (kidney doctor) or rheumatologist (musculoskeletal doctor)
- ☐ **2.4** Documented trial of glucocorticoids with mycophenolate mofetil (MMF) or cyclophosphamide for at least 3 months

Approval Time

- ☐ **3.1** Initial Approval: 12 months
- ☐ **3.2** Re-approval: 12 months with documentation of a beneficial response of therapy