

## **Pharmacy Drug Policy Checklist**

POLICY NAME Benlysta (belimumab) POLICY # 1798P

## Criteria

Criteria for Coverage for Systemic Lupus Erythematosus (SLE)	
	Age 5 years or older
	Prescribed by or in consultation with a rheumatologist (musculoskeletal doctor)
	Documented compliance with hydroxychloroquine or chloroquine, unless contraindicated • Compliance defined as possession of 150 days-worth of drug in 6 months
	Documented failure/intolerance/contraindication to treatment with at least one other standard therapy such as prednisone, azathioprine, leflunomide, methotrexate, mycophenolate, NSAIDs
rite	eria for Coverage for Lupus Nephritis
	Diagnosis of active lupus nephritis with an eGFR ≥ 45mL/min/1.73m2
	Age 5 years or older
	Prescribed by or in consultation with a nephrologist (kidney doctor) or rheumatologist (musculoskeletal doctor)
	Documented trial of glucocorticoids with mycophenolate mofetil (MMF) or cyclophosphamide for at least 3 months
xc	usion Criteria – Any of the following prevents coverage
	Treatment of severe active central nervous system lupus are considered experimental at this time due to a lack of studies which show efficacy
	When used in conjunction with biologic agents or intravenous cyclophosphamide
	Benlysta will not be covered if used in combination with Saphnelo or Lupkynis CPT Codes HCPCS Codes J0490 Injection, belimumab, 10 mg (Benlysta)