# Pharmacy Drug Policy Checklist

| POLICY NAME | Benlysta (belimumab) | POLICY # | 1798P |
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## Criteria

### 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

### 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)