Health Alliance™ Pharmacy Drug Policy Checklist

POLICY NAME	Benlysta (belimumab)	POLICY #	1798P

Criteria

Criteria for Coverage for Systemic Lupus Erythematosus (SLE)

- ☐ Diagnosis of active SLE including hematologic disease
- ☐ 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

Criteria 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

Exclusion 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)