**Policy Title:** Benlysta (belimumab) (Intravenous)

**Department:** PHA

**Effective Date:** 01/01/2020

**Review Date:** 10/02/2019, 12/18/2019, 1/22/2020, 1/11/2021, 4/22/2021

**Revision Date:** 10/02/2019, 1/22/2020, 1/11/2021, 4/22/2021

**Purpose:** To support safe, effective and appropriate use of Benlysta (belimumab).

**Scope:** Medicaid, Commercial, Medicare-Medicaid Plan (MMP)

**Policy Statement:**
Benlysta (belimumab) is covered under the Medical Benefit when used within the following guidelines. Use outside of these guidelines may result in non-payment unless approved under an exception process.

**Procedure:**
Coverage of Benlysta (belimumab) will be reviewed prospectively via the prior authorization process based on criteria below.

**Initial Criteria:**

MMP members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements.

**Systemic Lupus Erythematosus (SLE)**

- Patient is 5 years of age or older; AND
- Patient has a confirmed diagnosis of SLE with at least 4 diagnostic features (see list of diagnostic SLE criteria below)* one of which must include a positive autoantibody test (e.g., anti-nuclear antibody [ANA] greater than laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if tested by ELISA); AND
- Will not be used in combination with Lupkynis (voclosporin); AND
- Patient has failed to respond adequately to at least two (2) standard therapies such as anti-malarials, corticosteroids, non-steroidal anti-inflammatory drugs, or immunosuppressives (excluding intravenous cyclophosphamide); AND
- Patient has one of the following:
Safety of Estrogen in Lupus National Assessment - Systemic Lupus Erythematous Disease Activity Index (SELENA-SLEDAI) score of 6-12; OR

- British Isles Lupus Assessment Group (BILAG) B organ domain score ≥2; AND

- Patient must not have an active infection; AND
- Patient has not received a live vaccine within 30 days before starting or concurrently with Benlysta; AND
- Used in combination with standard therapy (e.g., anti-malarials, corticosteroids, nonsteroidal anti-inflammatory drugs, immunosuppressives); AND
- Patient does not have any of the following exclusion criteria:
  - Severe active central nervous system lupus
  - Individuals who are on other biologies

**Lupus Nephritis**

- Patient is at least 18 years of age; AND
- Patient must not have an active infection; AND
- Patient has not received a live vaccine within 30 days before starting or concurrently with Benlysta; AND
- Will not be used in combination with Lupkynis (voclosporin); AND
- Will be used in combination with standard therapy (e.g., anti-malarials, corticosteroids, nonsteroidal anti-inflammatory drugs, immunosuppressives); AND
- Patient does not have any of the following exclusion criteria:
  - Severe active central nervous system lupus
  - Individuals who are on other biologies; AND
- Patient has active lupus nephritis Class III, IV, or V as confirmed by renal biopsy; AND
- Patient has a confirmed diagnosis of SLE with at least 4 diagnostic features (see list of diagnostic SLE criteria below)* one of which must include a positive autoantibody test (e.g., anti-nuclear antibody [ANA] greater than laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if tested by ELISA); AND
- Patient has failed to respond adequately to standard therapies including corticosteroids AND either cyclophosphamide or mycophenolate mofetil; AND
- Baseline measurement of one or more of the following: urine protein:creatinine ratio (uPCR), estimated glomerular filtration rate (eGFR), or urine protein
Systemic Lupus Erythematous Diagnostic Criteria*

<table>
<thead>
<tr>
<th>Patient must have at least 4 out of 11 diagnostic SLE features:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Malar rash</td>
</tr>
<tr>
<td>2. Discoid rash</td>
</tr>
<tr>
<td>3. Photosensitivity</td>
</tr>
<tr>
<td>4. Oral ulcers</td>
</tr>
<tr>
<td>5. Nonerosive arthritis (involving 2 or more peripheral joints)</td>
</tr>
<tr>
<td>6. Pleuritis/pericarditis</td>
</tr>
<tr>
<td>a. Pleuritis - history of pleuritic pain or rubbing heard by a physician or evidence of pleural effusion</td>
</tr>
<tr>
<td>b. Pericarditis - documented by electrocardiogram or rubbing heard by a physician or evidence of pericardial effusion</td>
</tr>
<tr>
<td>7. Renal disorder</td>
</tr>
<tr>
<td>a. Persistent proteinuria &gt; 0.5 grams/day or &gt; 3+ on urine dipstick</td>
</tr>
<tr>
<td>b. Cellular casts (red cell, hemoglobin, granular, tubular, or mixed)</td>
</tr>
<tr>
<td>8. Seizures/psychosis</td>
</tr>
<tr>
<td>9. Hematologic disorder</td>
</tr>
<tr>
<td>a. Hemolytic anemia with reticulocytosis</td>
</tr>
<tr>
<td>b. Leukopenia &lt; 4,000/mm³ on ≥ 2 occasions</td>
</tr>
<tr>
<td>c. Lymphopenia &lt; 1,500/mm³ on ≥ 2 occasions</td>
</tr>
<tr>
<td>d. Thrombocytopenia &lt; 100,000/mm³ in the absence of offending drugs</td>
</tr>
<tr>
<td>10. Immunologic disorder</td>
</tr>
<tr>
<td>a. Presence of anti-Sm or antiphospholipid antibodies</td>
</tr>
<tr>
<td>b. Presence of anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if tested by ELISA</td>
</tr>
<tr>
<td>11. Positive anti-nuclear antibody [ANA] greater than laboratory reference range</td>
</tr>
</tbody>
</table>

Continuation of Therapy Criteria:

- Meets all initial criteria and is tolerating treatment; AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include:
  - the following: depression, suicidal thoughts, serious infections, signs or symptoms of progressive multifocal leukoencephalopathy (PML), malignancy, severe hypersensitivity reactions/anaphylaxis, serious infusion reactions, etc.; AND

SLE:

- Adequate documentation of disease stability and/or improvement as indicated by one or more of the following when compared to pre-treatment baseline:
  - Improvement in the SELENA-SLEDAI score of ≥4 points; OR
  - No new BILAG-A organ domain score or 2 new BILAG-B organ domain scores; OR
  - No worsening (<30-point point increase) in Physician’s Global Assessment (PGA) score; OR
  - Seroconverted (negative) or had a 20% reduction in autoantibody level; OR
Lupus Nephritis:
- Adequate documentation of disease stability and/or improvement as indicated by one or more of the following when compared to pre-treatment baseline:
  - Urine protein:creatinine ratio (uPCR): OR
  - Estimated glomerular filtration rate (eGFR): OR
  - Urine protein

Coverage durations:
- Initial coverage: 6 months
- Continuation of therapy coverage: 6 months

*** Requests will also be reviewed to National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) if applicable.***

Dosage/Administration:

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
<th>Maximum dose (1 billable unit = 10 mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLE or Lupus Nephritis</td>
<td><strong>Loading Dose:</strong> 10 mg/kg intravenously (by a healthcare provider) every 2 weeks x 3 doses (days 1, 15 and 29)</td>
<td><strong>Loading Dose (on days 1, 15 and 29):</strong> 360 billable units per 29 days</td>
</tr>
<tr>
<td></td>
<td><strong>Maintenance Dose:</strong> 10 mg/kg intravenously (by a healthcare provider) every 4 weeks</td>
<td><strong>Maintenance Dose:</strong> 120 billable units per 28 days</td>
</tr>
</tbody>
</table>

**Investigational use:** All therapies are considered investigational when used at a dose or for a condition other than those that are recognized as medically accepted indications as defined in any one of the following standard reference compendia: American Hospital Formulary Service Drug information (AHFS-DI), Thomson Micromedex DrugDex, Clinical Pharmacology, Wolters Kluwer Lexi-Drugs, or Peer-reviewed published medical literature indicating that sufficient evidence exists to support use. Neighborhood does not provide coverage for drugs when used for investigational purposes.

**Applicable Codes:**
Below is a list of billing codes applicable for covered treatment options. The below tables are provided for reference purposes and may not be all-inclusive. Requests received with codes from tables below do not guarantee coverage. Requests must meet all criteria provided in the procedure section.
The following HCPCS/CPT codes are:

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0490</td>
<td>Injection, belimumab, 10mg</td>
</tr>
</tbody>
</table>

References: