POLICY Document for BENLYSTA (belimumab)

The overall objective of this policy is to support the appropriate and cost-effective use of the medication, specific to use of preferred medication options, lower cost site of care and overall, clinically appropriate use. This document provides specific information to each of the three sections of the overall policy.

Section 1: Site of Care

- Policy information specific to site of care (outpatient, hospital outpatient, home infusion)

Section 2: Clinical Criteria

- Policy information specific to the clinical appropriateness for the medication

Section 1: Site of Care

CareFirst Site of Care Criteria Benlysta

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated.

Brand Name	Generic Name	Dosage Form
Benlysta	belimumab	intravenous

Criteria for Approval for Administration in Outpatient Hospital Setting

This policy provides coverage for administration of Benlysta in an outpatient hospital setting for up to 22 days when a member is new to therapy or is reinitiating therapy after not being on therapy for at least 6 months.

This policy provides coverage for administration of Benlysta in an outpatient hospital setting for a longer course of treatment when ANY of the following criteria are met:

- The member has experienced an adverse reaction to the medication that did not respond to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other

pre-medications or slowing of the infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion.
- The member is medically unstable (e.g., respiratory, cardiovascular, or renal conditions).
- The member has severe venous access issues that require the use of special interventions only available in the outpatient hospital setting.
- The member has significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver.
- Alternative infusion sites (pharmacy, physician office, ambulatory care, etc.) are greater than 30 miles from the member's home.
- The member is less than 14 years of age.

For situations where administration of Benlysta does not meet the criteria for outpatient hospital infusion, coverage for Benlysta is provided when administered in alternative sites such as physician office, home infusion or ambulatory care.

Required Documentation

The following information is necessary to initiate the site of care prior authorization review (where applicable):

- Medical records supporting the member has experienced an adverse reaction that did not respond to conventional interventions or a severe adverse event during or immediately after an infusion
- Medical records supporting the member is medically unstable
- Medical records supporting the member has severe venous access issues that requires specialized interventions only available in the outpatient hospital setting
- Medical records supporting the member has behavioral issues and/or physical or cognitive impairment and no access to a caregiver
- Records supporting alternative infusion sites are greater than 30 miles from the member's home
- Medical records supporting the member is new to therapy

Section 2: Clinical Criteria

Specialty Guideline Management
Benlysta

CVS/caremark

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Benlysta	belimumab

Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications[1]

Benlysta is indicated for the treatment of:

- Patients 5 years of age and older with active systemic lupus erythematosus (SLE) who are receiving standard therapy
- Patients 5 years of age and older with active lupus nephritis who are receiving standard therapy

Limitations of Use

The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system (CNS) lupus. Use of Benlysta is not recommended in this situation.

All other indications are considered experimental/investigational and not medically necessary.

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Initial requests

- Medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins), or kidney biopsy supporting the diagnosis (where applicable).

Continuation requests

- Medical records (e.g., chart notes, lab reports) documenting disease stability or improvement.

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Exclusions

Coverage will not be provided for members with any of the following exclusions:

Severe active central nervous system (CNS) lupus (including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebritis, or CNS vasculitis requiring therapeutic intervention before initiation of belimumab) in a member initiating therapy with Benlysta.
Member is using Benlysta in combination with other biologics.

Coverage Criteria

Systemic Lupus Erythematosus (SLE)[1-4,6,8]

Authorization of 12 months may be granted for treatment of active SLE when both of the following criteria are met:

- Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)
- The member is receiving a standard treatment for SLE with any of the following (alone or in combination):
  - Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
  - Antimalarials (e.g., hydroxychloroquine)
  - Immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)

Active Lupus Nephritis[1,4-5,7-8]

Authorization of 12 months may be granted for treatment of active lupus nephritis when both of the following criteria are met:

- Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or lupus nephritis was confirmed on kidney biopsy.
- Member is receiving a standard therapy regimen (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids).

Continuation of Therapy

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in the coverage criteria who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition.

REFERENCES

SECTION 1

1. Benlysta [package insert]. Philadelphia, PA: GlaxoSmithKline LLC.; June 2024.

SECTION 2

2. Benlysta [package insert]. Philadelphia, PA: GlaxoSmithKline LLC; June 2024.
3. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2023 Update of the EULAR Recommendations for the Management of Systemic Lupus Erythematosus. Ann Rheum Dis. 2024;83:15-29.
4. Rovin BH, Parikh SV, Hebert LA, et al. Lupus nephritis: induction therapy in severe lupus nephritis – should MMF be considered the drug of choice? Clin J Am Soc Nephrol. 2013;8(1):147-153.
5. Hahn BH, McMahon MA, Wilkinson A, et al. American College of Rheumatology guidelines for screening, treatment, and management of lupus nephritis. Arthritis Care & Research. 2012;64(6):797-808.
6. Furie R, Rovin BH, Houssiau F, et al. Two-Year, Randomized, Controlled Trial of Belimumab in Lupus Nephritis. N Engl J Med. 2020;383(12):1117-1128.
7. Aringer M, Costenbader K, Daikh D, et al. 2019 European League Against Rheumatism/American College of Rheumatology classification criteria for systemic lupus erythematosus. Ann Rheum Dis. 2019;78:1151-1159.
8. Rovin BH, Adler SG, Barratt J, et al. Kidney Disease: Improving Global Outcomes (KDIGO) Golmerular Disease Work Group. KDIGO 2021 Clinical Practice Guideline for the Management of Glomerular Diseases. Kidney Int. 2021 Oct; 100(4S):S1-S276.
9. Gordon C, Amissah-Arthru MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. Rheumatology (Oxford). 2018; 57(1):e1-e45.
10. Petri M, Orbai A-M, Alarcon GS, et al. Derivation and Validation of Systemic Lupus International Collaborating Clinics (SLICC) Classification Criteria for Systemic Lupus Erythematosus. Arthritis Rheum. 2012; 64:2677-2686. URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3409311/. Accessed January 21, 2025.