HealthPartners

Belimumab (Benlysta)

Systemic Lupus Erythematosus (SLE) Coverage Criteria:

1. Prescribed by a rheumatologist; and,
2. Used in the treatment of active, autoantibody-positive, systemic lupus erythematosus without severe active central nervous system disease; and,
3. Patient is currently being treated for systemic lupus erythematosus and all criteria below are met:
   a. A previous treatment course of hydroxychloroquine for at least six months resulting in failure or adverse event; and,
   b. A previous treatment course of at least one of the following immunosuppressive agents for at least three months:
      i. Mycophenolate, or
      ii. Azathioprine, or
      iii. Methotrexate, or
      iv. Cyclophosphamide, or
      v. Rituximab; and,
   c. Daily use of oral corticosteroids, unless contraindicated or previously not tolerated; and,
   d. No concurrent use of other biologics or intravenous cyclophosphamide.; and,
   e. Goals for therapy have been identified; and,
4. Prescribed within the FDA-approved dosing regimen of 200 mg once weekly.

Coverage Duration:
Initial authorizations and reauthorizations will be provided for 12 months

Renewal Criteria:
Authorized annually with provider attestation that they have seen the patient within the last **14** months and the patient is benefiting from use of the medication.

Lupus Nephritis (LN) Coverage Criteria:

1. Prescribed by a rheumatologist or nephrologist; and,
2. The patient has a documented diagnosis of Class III, IV, and/or V lupus nephritis. Medical documentation confirming the diagnosis must be provided; and,
3. Patient is without severe active central nervous system disease; and,
4. A previous treatment course of mycophenolate mofetil or cyclophosphamide for at least three months resulting in failure or adverse events; and,
5. The medication will be used concurrently with at least one other standard therapy (unless all standard therapies are contraindicated or previously not tolerated). Examples of standard therapies include (mycophenolate mofetil, cyclophosphamide, azathioprine); and,
6. The medication will not be prescribed in combination with Lupkynis; and,

7. Prescribed within the FDA-approved dosing regimen

Coverage Duration:
Initial authorizations and reauthorizations will be provided for 12 months

Renewal Criteria:
1. Patient continues to meet initial prior authorization criteria (1), (3), (5), (6) and (7); and,
2. Patient has been seen by the specialist within the past 14 months; and,
3. Patient has had a clinically meaningful response (e.g. decrease or stabilization of symptoms, decrease of corticosteroid dose and/or pain medications, reduction in flares, improvement in organ dysfunction).