Benlysta (belimumab)  
Effective 10/01/2021

<table>
<thead>
<tr>
<th>Plan</th>
<th>Program Type</th>
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</table>
| ☒ MassHealth  
☐ Commercial/Exchange | ☒ Prior Authorization  
☐ Quantity Limit  
☐ Step Therapy |

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Specialty Limitations</th>
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| ☐ Pharmacy Benefit  
☒ Medical Benefit (NLX) | N/A |

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<tr>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
<th>Medical Specialty Medications (NLX)</th>
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<tbody>
<tr>
<td>All Plans Phone: 866-814-5506 Fax: 866-249-6155</td>
<td>MassHealth Phone: 877-433-7643 Fax: 866-255-7569</td>
<td>All Plans Phone: 844-345-2803 Fax: 844-851-0882</td>
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<tr>
<td>Commercial Phone: 800-294-5979 Fax: 888-836-0730</td>
<td>Exchange Phone: 855-582-2022 Fax: 855-245-2134</td>
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<th>Exceptions</th>
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<td>N/A</td>
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**Overview**
Benlysta is a monoclonal antibody indicated for Lupus nephritis and Systemic lupus erythematosus (SLE). Benlysta is available for subcutaneous or intravenous administration.

**Coverage Guidelines**
Authorization may be reviewed for members new to AllWays Health Partners who are currently receiving treatment with Benlysta excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

**Active Lupus Nephritis**
1. The member is ≥ 18 years of age
2. Documentation submitted confirming member is positive for autoantibodies to SLE
3. The member is receiving a stable standard induction and maintenance treatment for lupus nephritis (e.g. cyclophosphamide, mycophenolate mofetil, azathioprine, glucocorticoids)

Authorization may be granted for treatment of active SLE when ALL of the following criteria are met, and documentation is provided:

**Systemic lupus erythematosus (SLE)**
1. The member is ≥ 5 years of age
2. Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE
3. The member is receiving a stable standard treatment for SLE with any of the following (alone or in combination):
   i. Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
ii. Antimalarials (e.g., hydroxychloroquine)
iii. Immunosuppressants

**Continuation of Therapy**
Reauthorization may be granted for continued treatment in members requesting reauthorization for an indication listed above who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition.

**Limitations**
Initial approvals and reauthorizations may be granted for 12 months.

**References**
1. Benlysta (belimumab) [prescribing information]. Philadelphia, PA: GlaxoSmithKline LLC; March 2021

**Review History**
07/21/2021- Reviewed for July P&T; switch from CVS SGM criteria to AllWays Health Partners custom criteria. Effective 10/01/2021.

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