

**Benlysta (belimumab)
Effective 10/01/2021**

Plan	<input type="checkbox"/> MassHealth <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input type="checkbox"/> Pharmacy Benefit <input checked="" type="checkbox"/> Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	Specialty Medications		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

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

Disclaimer

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