Mass General Brigham
Health Plan

Benlysta (belimumab)
Effective 07/01/2023

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
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 the plan 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
09/21/2022 – Reviewed and updated for September P&T. Separated out Comm/Exch vs. MassHealth.
04/12/2023 – Reviewed and Updated for April P&T; added SQ version to be added to the pharmacy benefit. IV version will continue to be available on the MB. Effective 7/1/2023.