

Benlysta (belimumab)
Effective 01/01/2026

Plan	<input type="checkbox"/> MassHealth UPPL <input checked="" type="checkbox"/> Commercial/Exchange	Program Type	<input checked="" type="checkbox"/> Prior Authorization <input type="checkbox"/> Quantity Limit <input type="checkbox"/> Step Therapy
Benefit	<input checked="" type="checkbox"/> Pharmacy Benefit <input type="checkbox"/> Medical Benefit		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	Medical Benefit Pharmacy Benefit	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview

Benlysta is a monoclonal antibody indicated for active lupus nephritis and active systemic lupus erythematosus (SLE). Benlysta is available for subcutaneous or intravenous administration

Coverage Guidelines

Authorization may be reviewed for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, 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 \geq 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 \geq 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.

10/08/2025 – Reviewed and updated for October P&T. Updated policy to reflect that it no longer applies to the medical benefit. Effective 01/01/2026.

