

## **Clinical Policy: Belimumab (Benlysta)**

Reference Number: CP.PHAR.88

Effective Date: 10.01.11

Last Review Date: 05.21

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Belimumab (Benlysta<sup>®</sup>) is B-lymphocyte stimulator specific inhibitor.

### **FDA Approved Indication(s)**

Benlysta is indicated for the treatment of:

- Patients aged 5 years and older with active, autoantibody-positive, systemic lupus erythematosus (SLE) who are receiving standard therapy.
- Adult patients with active lupus nephritis (LN) who are receiving standard therapy.

Limitation(s) of use: The efficacy of Benlysta has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Benlysta has not been studied in combination with other biologics or intravenous cyclophosphamide. Use of Benlysta is not recommended in these situations.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Benlysta is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Systemic Lupus Erythematosus (must meet all):**

1. Diagnosis of SLE;
2. Prescribed by or in consultation with a rheumatologist;
3. Age  $\geq$  5 years;
4. Documentation confirms that member is positive for an SLE autoantibody (e.g., anti-nuclear antibody (ANA), anti-double-stranded DNA (anti-dsDNA), anti-Smith (anti-Sm), anti-ribonucleoprotein (anti-RNP), anti-Ro/SSA, anti-La/SSB, antiphospholipid antibody);
5. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
6. Request meets one of the following (a or b):
  - a. Adults ( $\geq$  18 years of age):
    - i. IV: Dose does not exceed 10 mg/kg/dose at 2-week intervals for the first 3 doses and at 4-week intervals thereafter;

- ii. SC: 200 mg/week;
- b. Pediatrics ( $\geq 5$  years of age): Dose does not exceed 10 mg/kg/dose IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.

**Approval duration:**

**Medicaid/HIM** – 6 months

**Commercial** – 6 months or to member’s renewal date, whichever is longer

**B. Lupus Nephritis (must meet all):**

1. Diagnosis of LN with kidney biopsy that confirms one of the following (a, b, or c):
  - a. LN Class III (focal);
  - b. LN Class IV (diffuse segmental or global);
  - c. LN Class V (membranous);
2. Prescribed by or in consultation with a nephrologist or rheumatologist;
3. Age  $\geq 18$  years;
4. Member has a confirmed diagnosis of systemic lupus erythematosus;
5. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
6. Dose does not exceed 400 mg/week SC for the first 4 doses\*, then 200 mg/week SC;  
*\*Loading doses not permitted if previously receiving Benlysta for treatment of SLE*

**Approval duration:**

**Medicaid/HIM** – 6 months

**Commercial** – 6 months or to member’s renewal date, whichever is longer

**C. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. All Indications in Section I (must meet all):**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member meets one of the following (a or b):
  - a. For SLE: member is responding positively to therapy;
  - b. For LN: member is responding positively to therapy as evidenced by one of the following (i, ii, or iii):
    - i. Reduced level of proteinuria measured by UPCR  $\leq 0.5$  mg/mg from baseline with low dose steroids (e.g., prednisone);
    - ii. No reduction from baseline in eGFR of greater than 20% with low dose steroids (e.g., prednisone);
    - iii. eGFR  $\geq 60$  ml/min/1.73 m<sup>2</sup> with low dose steroids (e.g., prednisone);
3. Prescribed in combination with standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g.,

- prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
4. If request is for a dose increase, request meets one of the following (a or b):
    - a. Adults ( $\geq 18$  years of age):
      - i. IV: Dose does not exceed 10 mg/kg/dose at 2-week intervals for the first 3 doses and at 4-week intervals thereafter;
      - ii. SC: 200 mg/week;
    - b. Pediatrics ( $\geq 5$  years of age): Dose does not exceed 10 mg/kg/dose IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 6 months or to member’s renewal date, whichever is longer

**B. Other diagnoses/indications (1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.
- B. Autoantibody negative SLE.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

ANA: anti-nuclear antibody

Anti-dsDNA: anti-double-stranded DNA

Anti-Sm: anti-Smith

DNA: deoxyribonucleic acid

FDA: Food and Drug Administration

LN: lupus nephritis

SLE: systemic lupus erythematosus

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glucocorticoids (e.g., prednisone)	Varies	Varies
antimalarial agents (e.g., hydroxychloroquine, chloroquine)	Varies	Varies
non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate)	Varies	Varies

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): previous anaphylaxis to belimumab
- Boxed warning(s): none reported

*Appendix D: Autoantibody Positive Versus Negative SLE*

Only one of the five Benlysta pivotal trials included patients with autoantibody negative SLE; no significant differences between any of the Benlysta groups and the placebo group were observed. However, on further analysis Benlysta appeared to offer benefit to a subgroup of autoantibody positive patients. Benlysta’s efficacy was confirmed in the remaining four trials which included only autoantibody positive patients. Because of the apparent lack of efficacy in autoantibody negative patients and because the FDA has approved Benlysta in only autoantibody positive patients, Benlysta coverage will not be authorized for patients with autoantibody negative SLE.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
SLE, Lupus Nephritis	<ul style="list-style-type: none"> <li>• IV (pediatrics and adults)                             <ul style="list-style-type: none"> <li>○ 10 mg/kg at 2 week intervals for the first 3 doses and at 4 week intervals thereafter</li> </ul> </li> <li>• SC (adults only)                             <ul style="list-style-type: none"> <li>○ For SLE, 200 mg once weekly</li> <li>○ For lupus nephritis, 400 mg once weekly for 4 doses, then 200 mg once weekly</li> </ul> </li> <li>• Transition from IV to SC therapy (adults)                             <ul style="list-style-type: none"> <li>○ Administer first SC dose 1 to 4 weeks after the last IV dose</li> </ul> </li> </ul>	IV: 10 mg/kg/dose SC: 200 mg/week

**VI. Product Availability**

- Single-dose vial: 120 mg and 400 mg lyophilized powder for reconstitution
- Single-dose prefilled autoinjector/syringe: 200 mg/mL

**VII. References**

1. Benlysta Prescribing Information. Research Triangle Park, NC: GlaxoSmithKline; December 2020. Available at <http://www.benlysta.com>. Accessed December 22, 2020.
2. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. *Ann Rheum Dis.* 2019;0:1–10. doi:10.1136/annrheumdis-2019-215089.
3. Petri M, Orbai AM, Alarcón GS, et al. Derivation and validation of the Systemic Lupus International Collaborating Clinics classification criteria for systemic lupus erythematosus. *Arthritis Rheum.* 2012; 64:2677.
4. Gordon C, Amissah-Arthur MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. *Rheumatology.* 2018;57:e1-e45. doi:10.1093/rheumatology/kex286.

5. Furie R, Rovin B, Houssiau F, et al. Two-year randomized, controlled trial of belimumab in lupus nephritis. *N Engl J Med.* 2020;383(12):1117-1128. doi: 10.1056/NEJMoa2001180.

**Coding Implications**

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0490	Injection, belimumab, 10 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Safety criteria applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	11.17
3Q 2018 annual review: Policies combined for Commercial and Medicaid lines of business; HIM-Medical added; no significant changes from previously approved corporate policy; Medicaid: added prescriber requirement, removed requirement to confirm lack of chronic infection treatment, expanded list of accepted autoantibodies consistent with existing Commercial approach; references reviewed and updated.	05.09.18	08.18
3Q 2019 annual review: labeled age updated from adults down to age 5 and older; antiphospholipid antibody added to examples of SLE antibodies; added separate approval duration for commercial line of business to the continued therapy section; added that concurrent standard therapy be continued in the continued approval section; references reviewed and updated.	05.14.19	08.19
3Q 2020 annual review: no significant changes; revised from HIM-Medical Benefit to HIM line of business; references reviewed and updated.	05.12.20	08.20
RT4: added criteria to reflect new indication for lupus nephritis in adults and aligned with Lupkynis (voclosporin); updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21).	02.16.21	05.21

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

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This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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