Pharmacy Medical Necessity Guidelines: Benlysta® (belimumab)

Effective: October 23, 2017

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<th>Prior Authorization Required</th>
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<th>Type of Review – Care Management</th>
<th>Type of Review – Clinical Review</th>
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<td>Pharmacy (RX) or Medical (MED) Benefit</td>
<td>MED /RX</td>
<td>Department to Review</td>
<td>PRECERT /MM /RXUM</td>
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This Pharmacy Medical Necessity Guideline applies to the following:

**Tufts Health Plan Commercial Plans**
- Tufts Health Plan Commercial Plans – large group plans
- Tufts Health Plan Commercial Plans – small group and individual plans

**Tufts Health Public Plans**
- Tufts Health Direct – Health Connector
- Tufts Health Together – A MassHealth Plan
- Tufts Health RITogether – A Rite Care + Rhody Health Partners Plan

**Tufts Health Freedom Plan products**
- Tufts Health Freedom Plan - large group plans
- Tufts Health Freedom Plan - small group plans

Fax Numbers:
- All plans except Tufts Health Public Plans: PRECERT: 617.972.9409
- Tufts Health Direct – Health Connector: MM: 888.415.9055
- Tufts Health Together – A MassHealth Plan: RxUM: 617.673.0988

**Note:** For Tufts Health Plan Medicare Preferred Members, please refer to the Tufts Health Plan Medicare Preferred Prior Authorization Criteria. Background, applicable product and disclaimer information can be found on the last page.

**OVERVIEW**

**FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS**

Benlysta (belimumab) is a B-lymphocyte stimulator (BLys)-specific inhibitor indicated for the treatment of adult patients with active, autoantibody-positive, systemic lupus erythematosus who are receiving standard therapy.

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

Benlysta (belimumab) may be administered as an intravenous infusion or as a subcutaneous injection. Vials are intended for intravenous use only and autoinjectors and prefilled syringes are intended for subcutaneous use only.

**COVERAGE GUIDELINES**

The plan may authorize coverage of Benlysta (belimumab) for Members, when ALL of the following criteria are met:

1. Documented diagnosis of active, autoantibody positive (e.g. ANA, anti-ds-DNA, anti-Sm) systemic lupus erythematosus

   AND

2. Prescriber is a rheumatologist

   AND

3. The Member is concurrently taking and is compliant with standard therapy for systemic lupus erythematosus (e.g., corticosteroids, antimalarials, or immunosuppressives – alone or in combination).

**LIMITATIONS**

1. Benlysta (belimumab) will not be approved in the following instances:
   - As Monotherapy
   - For Members with severe active lupus nephritis or severe active central nervous system lupus
   - For Members who are autoantibody negative
   - In combination with other biologics and / or intravenous cyclophosphamide

2. Initial authorization for Benlysta (belimumab) will be limited to 6 months.
3. For subsequent coverage requests, please submit documentation that a clinical benefit has been established and maintained compared to baseline. Reauthorization will be limited to 12-month intervals.

4. Benlysta (belimumab) autoinjector and prefilled syringes are covered under the pharmacy benefit. Benlysta (belimumab) vials are covered under the medical benefit.

CODES
The following HCPCS/CPT code(s) are:

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J0490</td>
<td>Injection, belimumab, 10 mg</td>
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REFERENCES
8. FDA Briefing Information, Belimumab (Benlysta), for the November 16, 2010 Meeting of the Arthritis Advisory Committee.
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Benlysta® (belimumab)

APPROVAL HISTORY
July 12, 2011: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
- January 1, 2012: Administrative update: Added HCPCS code J0490
- June 12, 2012: Administrative update: Removed HCPCS code Q2044
- May 14, 2013: No changes.
- April 8, 2014: No changes.
- March 10, 2015: No changes.
- January 1, 2016: Administrative change to rebranded template
- March 8, 2016: No changes.
- March 14, 2017: No changes.
- October 17, 2017: Added Benlysta for subcutaneous use to the Medical Necessity Guideline.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with a Member's benefit document and in coordination with the Member's physician(s). The plan makes coverage decisions on a case-by-case basis considering the individual Member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

This Pharmacy Medical Necessity Guideline does not apply to Uniformed Services Family Health Plan Members or to certain delegated service arrangements. Unless otherwise noted in the Member's benefit document or applicable Pharmacy Medical Necessity Guideline, Pharmacy Medical Necessity Guidelines do not apply to CareLinkSM Members. For self-insured plans, drug coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a coverage guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates will take precedence.

For Tufts Health Plan Medicare Preferred, please refer to Tufts Health Plan Medicare Preferred Prior Authorization Criteria.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to Member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.