<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>Benlysta (belimumab)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BILLING CODE</td>
<td>For medical - J0490</td>
</tr>
<tr>
<td></td>
<td>For Rx - must use valid NDC</td>
</tr>
<tr>
<td>BENEFIT TYPE</td>
<td>Medical or Pharmacy</td>
</tr>
<tr>
<td>SITE OF SERVICE ALLOWED</td>
<td>Outpatient/Office/Home</td>
</tr>
<tr>
<td>COVERAGE REQUIREMENTS</td>
<td>Prior Authorization Required (Non-Preferred Product)</td>
</tr>
<tr>
<td></td>
<td>QUANTITY LIMIT — N/A</td>
</tr>
<tr>
<td>LIST OF DIAGNOSES CONSIDERED NOT MEDICALLY NECESSARY</td>
<td>Click Here</td>
</tr>
</tbody>
</table>

Benlysta (belimumab) is a **non-preferred** product and will only be considered for coverage under the **medical or pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

**SYSTEMIC LUPUS ERYTHEMATOSUS**

**For Initial authorization:**
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by a rheumatologist; AND
3. Member must have active disease with SELENA-SLEDAI score of 6 or greater (documented in chart notes) prior to initiating Benlysta; AND
4. Member is autoantibody-positive with chart notes documentation of anti-nuclear antibody (ANA) titer ≥1:80 and/or anti-double-stranded DNA (anti-dsDNA) ≥30 IU/mL; AND
5. Member meets ALL of the following:
   a) Member requires daily use of oral corticosteroids, unless contraindicated, or previously ineffective or not tolerated;
   b) Member has tried and failed to respond to treatment with at least **two** of the following: chloroquine, hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide, or mycophenolate mofetil for at least 12 weeks;
   c) Member is not currently on intravenously administered cyclophosphamide or another biologic agent.
6. **Dosage allowed:** Intravenously 10 mg/kg at 2 week intervals for first 3 doses and at 4 week intervals thereafter. Subcutaneously 200 mg once weekly.

**If member meets all the requirements listed above, the medication will be approved for 6 months.**

**For reauthorization:**
1. Member must be in compliance with all other initial criteria; AND
2. Member has SELENA-SLEDAI score improvement documented in chart notes; AND
3. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

**If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.**
CareSource considers Benlysta (belimumab) not medically necessary for the treatment of the diseases that are not listed in this document.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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<tr>
<td>10/18/2017</td>
<td>New policy for Benlysta created. Length of approval was increased, system involvement limitations were removed and improvement of SELENA-SLEDAI score was added in reauthorization.</td>
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</tbody>
</table>

References:

Effective date: 11/08/2017
Revised date: 10/18/2017