oscar

Clinical Guideline

Oscar Clinical Guideline: Benlysta (belimumab) (PG014, Ver. 7)

Benlysta (belimumab)

- Benlysta (belimumab) [120mg, 400mg] Powder for Injection
- Benlysta (belimumab) SC 200 mg/mL Autoinjector Solution for Injection
- Benlysta (belimumab) SC 200 mg/mL Prefilled Syringe Solution for Injection

Disclaimer

Clinical guidelines are developed and adopted to establish evidence-based clinical criteria for utilization management decisions. Clinical guidelines are applicable according to policy and plan type. The Plan may delegate utilization management decisions of certain services to third parties who may develop and adopt their own clinical criteria.

Coverage of services is subject to the terms, conditions, and limitations of a member's policy, as well as applicable state and federal law. Clinical guidelines are also subject to in-force criteria such as the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) for Medicare Advantage plans. Please refer to the member's policy documents (e.g., Certificate/Evidence of Coverage, Schedule of Benefits, Plan Formulary) or contact the Plan to confirm coverage.

Summary

Benlysta (belimumab) is a B-lymphocyte stimulator (BLyS)-specific inhibitor indicated for the treatment of:

- Patients 5 years of age and older with active systemic lupus erythematosus (SLE) who are receiving standard therapy.
- Patients 5 years of age and older with active lupus nephritis who are receiving standard therapy.

Benlysta is available as both an intravenous (IV) infusion and a subcutaneous (SC) injection.

- **Preferred Formulation:** The subcutaneous formulation of Benlysta (belimumab) is preferred over the intravenous formulation.
    - Vials are for intravenous administration only.
    - Autoinjectors and prefilled syringes are for subcutaneous administration only.

    - Vials are not intended for subcutaneous injection or autoinjectors/prefilled syringes for intravenous infusion.

  NOTE: *For full dosage and administration information, please refer to the current prescribing information.*
- Members should use the SC formulation unless specific exception criteria for IV administration are met (see Additional Exception Criteria for Intravenous Administration).

Definitions

"Antimalarial" is a drug class that is used to treat malaria but also is used in autoimmune diseases such as lupus and rheumatoid arthritis.

"Autoantibody" is an antibody produced by one's own immune system that attacks the body's normal cells, rather than foreign antigens (such as viruses and bacteria).

"B cells" are cells in the body that help activate an immune response.

"B lymphocyte stimulator protein (BLyS)" is a molecule in the body that aids in the development of B cells.

"Central nervous system lupus" is a complication that can be seen in lupus patients and can involve conditions such as seizures, cerebrovascular accidents (strokes), delirium, and nerve pain.

"Corticosteroid" is a drug class that reduces inflammation and suppresses the immune system.

"Human monoclonal antibody" is a protein made from human cells that is designed to bind to a specific molecule in the body and can be used to treat a variety of diseases including lupus, rheumatoid arthritis, and cancers.

"Immunosuppressives" are medications that prevent the actions of the immune system, used in diseases such as lupus, rheumatoid arthritis, psoriasis, and Crohn's disease.

"JCV" or "John Cunningham virus" refers to a virus associated with the development of progressive multifocal leukoencephalopathy (PML), a side effect of certain immunosuppressive medications. Patients who use Benlysta should be tested for JCV before starting treatment and while on treatment to help identify if they are at a higher risk for PML.

"Lupus nephritis" is inflammation of the kidney in patients with lupus.

Medical Necessity Criteria for Initial Authorization

The Plan considers **Benlysta (belimumab)** medically necessary when recent (within the last 6 months) clinical chart documentation is provided indicating the **ALL** the following criteria are met for the applicable indication listed below:

For active systemic lupus erythematosus

1. The medication is being prescribed by a rheumatologist; ***AND***
2. The member is 5 years of age or older; ***AND***
3. The member has a diagnosis of active systemic lupus erythematosus and meets **BOTH** of the following conditions:
    a. Positive for autoantibodies (antinuclear antibody [ANA] and/or anti-double-stranded DNA [anti-dsDNA])***; and***
    b. Receiving standard therapy, which includes at least **ONE** of the following, alone or in combination:
        i. antimalarials (such as hydroxychloroquine)***; or***
        ii. corticosteroids (such as prednisone, methylprednisolone, dexamethasone); ***or***
        iii. immunosuppressives (such as azathioprine, methotrexate, mycophenolate)***; AND***
4. The member does not have severe active central nervous system lupus (such as altered mental function or confusion, vision problems, or seizures); ***AND***
5. The member is not using Benlysta in combination with **ANY** of the following:
    a. other biologic therapies (such as Actemra, Enbrel, Humira, Stelara); ***or***
    b. intravenous cyclophosphamide; ***AND***
6. The member must have no evidence of infection, specifically tuberculosis (TB), Hepatitis B (HBV), or Hepatitis C (HCV); ***AND*** *(if applicable, for Intravenous Benlysta)*

For active lupus nephritis

1. The medication is being prescribed by a rheumatologist or nephrologist; ***AND***
2. The member is 5 years of age or older; ***AND***
3. The member has a diagnosis of active lupus nephritis and meets **BOTH** of the following conditions:
    a. Positive for autoantibodies (antinuclear antibody [ANA] and/or anti-double-stranded DNA [anti-dsDNA]); ***and***
    b. Receiving standard therapy, which includes at least **ONE** of the following, alone or in combination:
        i. calcineurin inhibitors (such as cyclosporine, tacrolimus)***; or***
        ii. corticosteroids (such as prednisone, methylprednisolone, dexamethasone); ***or***

iii. immunosuppressives (such as azathioprine, mycophenolate)***; AND***

4. The member does not have severe active central nervous system lupus (such as altered mental function or confusion, vision problems, or seizures); ***AND***
5. The member is not using Benlysta in combination with other biologic therapies (such as Actemra, Enbrel, Humira, Stelara); ***AND***
6. The member must have no evidence of infection, specifically tuberculosis (TB), Hepatitis B (HBV), or Hepatitis C (HCV); ***AND*** *(if applicable, for Intravenous Benlysta)*

Additional Exception Criteria for Intravenous Administration

7. *The Plan requires all members to use Benlysta (belimumab) subcutaneous (SC) formulation for initial therapy and maintenance treatment.* **Benlysta (belimumab) for intravenous (IV) infusion** will be authorized only when the member meets **ONE** of the following:
    a. The member has a documented contraindication to the subcutaneous (SC) formulation that would **NOT** be expected to occur with the IV formulation; ***OR***
    b. The member has demonstrated a clinical response to Benlysta SC but is unable to continue due to severe injection site reactions that are not manageable with standard interventions (e.g., persistent severe pain, recurrent large areas of erythema, severe pruritus unresponsive to treatment); ***OR***
    c. The member experienced a documented intolerable adverse event to the SC formulation of Benlysta that would **NOT** be expected to occur with the IV formulation; ***OR***
    d. The member has physical or cognitive limitations that prevent SC self-administration or administration by a caregiver, including but not limited to visual impairment, limited manual dexterity, or impaired cognitive function (documentation required); ***OR***
    e. The member has a documented medical condition that significantly impairs subcutaneous absorption, making IV administration necessary for effective treatment (e.g., severe lipodystrophy, extensive scarring over injection sites, scleroderma with significant skin thickening); ***OR***
    f. The member requires a dose that is **NOT** available or feasible for SC administration; ***OR***
    g. The prescriber provides a clear clinical rationale, supported by documentation, for why Benlysta IV is expected to be beneficial despite failure or intolerance of Benlysta SC.

If the above prior authorization criteria are met, Benlysta (belimumab) will be approved for up to 12-months.

➢ *Subcutaneous administration is the preferred route and should be used for initial therapy and maintenance treatment unless exception criteria for IV administration are met.*

Medical Necessity Criteria for Reauthorization

Reauthorization for 12 months will be granted if **BOTH** of the following are met:

1. the member still meets the applicable Initial Authorization criteria***; and***
2. recent chart documentation (within the last 6 months) shows **ONE** of the following:
    a. the member has shown a clinical improvement (e.g., sustained improvement in disease activity and reductions in disease flares) in symptoms since starting the requested medication***; or***
    b. the member has experienced disease stability (e.g., complete remission, low disease activity state, no new lupus disease activity compared with the previous assessment) since starting the requested medication.

Experimental or Investigational / Not Medically Necessary

Benlysta (belimumab) for any other indication is considered not medically necessary by the Plan, as it is deemed to be experimental, investigational, or unproven. Non-covered indications include, but are not limited to, the following:

- Immunoglobulin G4 Related Sclerosing Disease
- Immune Thrombocytopenia (ITP)
- Anti-Neutrophil Cytoplasmic Antibody-Associated Vasculitis / Granulomatosis With Polyangiitis
- Chronic Obstructive Pulmonary Disease (COPD) / Emphysema
- Myasthenia Gravis
- Rheumatoid Arthritis
- Sjogren's Syndrome (SS)
- Cryoglobulinemia
- Vasculitis
- Relapsed Chronic Lymphocytic Leukemia
- Anti-Phospholipids Syndrome (APS)
- Graft-versus-host Disease (GVHD)
- Idiopathic CD4 Lymphocytopenia
- Neuromyelitis Optica Spectrum Disorders
- Discoid Lupus Erythematosus (DLE)

Additionally, the Plan requires all members to use the subcutaneous formulation of Benlysta for initial therapy and maintenance treatment, unless specific exception criteria for intravenous administration are met and documented. Use of the intravenous formulation without meeting these criteria or continuing

intravenous administration when transition to subcutaneous administration is feasible is considered not medically necessary.

Applicable Billing Codes (HCPCS/CPT Codes)

CPT/HCPCS Codes for Applicable Medications	
Code	***Description***
J0490	Benlysta IV Injection, belimumab, 10 mg
J3590	Benlysta SC (belimumab) Unclassified biologics
ICD-10-CM Codes for Clinical Indications	
Codes	***Description***
Systemic Lupus Erythematosus	
M32.0	Drug-induced systemic lupus erythematosus
M32.10	Systemic lupus erythematosus, organ or system involvement unspecified
M32.11	Endocarditis in systemic lupus erythematosus
M32.12	Pericarditis in systemic lupus erythematosus
M32.13	Lung involvement in systemic lupus erythematosus
M32.15	Tubulo-interstitial nephropathy in systemic lupus erythematosus
M32.19	Other organ or system involvement in systemic lupus erythematosus
M32.8	Other forms of systemic lupus erythematosus
M32.9	Systemic lupus erythematosus, unspecified
Lupus Nephritis	
M32.14	Glomerular disease in systemic lupus erythematosus

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Clinical Guideline Revision / History Information

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