Medical benefit drug policies are a source for BCBSM and BCN medical policy information only. These documents are not to be used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information. This policy may be updated and therefore subject to change.

Effective Date: 06/11/2020

Benlysta® (belimumab)

FDA approval: 03/09/2011
HCPCS: J0490
Benefit: Medical

Policy:

Requests must be supported by submission of chart notes and patient specific documentation.

A. Coverage of the requested drug is provided when all the following are met:
   a. FDA approved indication
   b. FDA approved age
   c. Patients have tested positive for serum antibodies at 2 independent time points
   d. Patients have active disease as indicated by a score on the safety of estrogens in Lupus Erythematosus National Assessment modification on the SLE Disease Activity Index (SELENA-SLEDAI) of at least 6
   e. Patient does not have severe lupus nephritis
   f. Patient does not have active nephritis or active central nervous system lupus
   g. Previous treatment courses of at least 12 weeks each with 2 or more of the following have been ineffective: chloroquine, hydroxychloroquine, methotrexate, azathioprine, cyclophosphamide OR mycophenolate mofetil, unless all are contraindicated or not tolerated
   h. Patient is currently receiving and will continue to receive a stable standard of care regimen. Standard of care treatment regimen comprise of any of the following drug classes, alone or in combination:
      i. Antimalarials
      ii. Corticosteroids
      iii. Non-biologic immunosuppressants
   i. Not to be used in combination with other biologics (ex. Humira) or intravenous cyclophosphamide
   j. Trial and failure, contraindication, or intolerance to the preferred drugs as listed in BCBSM/BCN's prior authorization and step therapy documents or BCBSM/BCN's medical utilization management drug list.

B. Quantity Limitations, Authorization Period and Renewal Criteria
   a. Quantity Limits: Align with FDA recommended dosing
   b. Initial Authorization Period: 6 months
   c. Renewal Authorization Period: 1 year
   d. Renewal Criteria: Documentation of a decrease on the SELENA-SLEDAI or stability of disease while on therapy
Therapeutic considerations:

A. FDA approved indication / Diagnosis
   a. Treatment of adult patients with active, autoantibody positive, systemic lupus erythematosus who are receiving standard therapy
   b. Limitations of Use: Use is not recommended in patients with severe active lupus nephritis, severe active CNS lupus, or in combination with other biologics including B-cell targeted therapies or intravenous cyclophosphamide

*Please refer to most recent prescribing information.

B. Background Information
   a. 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.
   b. The efficacy of Benlysta has not been evaluated in patients with severe active lupus nephritis or severe active central nervous system lupus. Severe lupus nephritis was defined as proteinuria > 6 g/24 hours or serum creatinine > 2.5 mg/dL in the clinical trials. Active nephritis can also be diagnosed when there are significant white and red blood cells on urinalysis. Severe active central nervous system lupus was defined as seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis, or CNS vasculitis requiring therapeutic intervention within the previous 60 days before initiation of Benlysta in the clinical trials. Use of Benlysta in patients with these conditions is not recommended.
   c. Use of Benlysta also has not been studied in combination with other biologics or intravenous cyclophosphamide and is not recommended.
   d. Seropositivity was defined in the clinical trials by 2 positive ANA titers (≥ 1:80) or anti-dsDNA antibodies (≥ 30 IU/mL) on different days. The 2019 EULAR/ACR classification system for SLE allow ANA levels to be used as a qualifier for SLE, however, because ANA can elevate transiently and also be a marker for other diagnoses, a second confirmatory test must be done to confirm seropositivity. While other classification systems exist to define lupus, these systems do not ensure patients are seropositive as they only have to meet a certain number of criterion for diagnosis. Those criterion may or may not include positive tests for elevated ANA or anti-dsDNA titers.
   e. Both the intravenous and subcutaneous formulations of Benlysta were studied in phase III, multicenter, randomized, placebo-controlled trials. The intravenous formulation was assessed in the BLISS-76 and BLISS-52 trials and the subcutaneous formulation in the BLISS-SC trial. All trials included seropositive patients who were stable and maintained on standard therapy throughout the study. People with severe lupus nephritis or severe CNS lupus were excluded. Subjects were required to have a SELENA-SLEDAI score greater than 6 in the intravenous trials and greater than 8 in the subcutaneous trials. Primary endpoints for both studies were the SLE Responder Index (SRI4) response rate at week 52. The SRI4 is a composite index requiring a 4-point reduction in the SELENA–SLEDAI score, no worsening (increase from baseline) in the physician’s global assessment (on a 0 – 10-cm visual analog scale), and no new British Isles Lupus Assessment Group (BILAG) A organ domain score or 2 new BILAG B organ domain scores at week 52 compared with baseline. In all studies, the Benlysta treatment arms showed statistical significance verse placebo for the primary endpoint.
   f. The 2020 EULAR guidelines recommend use of hydroxychloroquine in all patients with the use of glucocorticoids to treat flares. The goal of therapy is for patients to get into remission or a state of low...
disease activity. If hydroxychloroquine use is still resulting in disease flare, use of immunosuppressants should be considered. The guidelines state Benlysta should be considered in patients who have failed hydroxychloroquine in combination with glucocorticoids and immunosuppressants.

C. Efficacy

*Please refer to most recent prescribing information.

D. Medication Safety Considerations

Black Box Warning: No

*Please refer to most recent prescribing information

E. Dosing and administration

a. Recommended dosage regimen is 10 mg/kg at 2-week intervals for the first 3 doses and at 4-week intervals thereafter. Reconstitute, dilute and administer as an intravenous infusion only, over a period of 1 hour

b. Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions

*Please refer to most recent prescribing information.

F. How supplied

a. 120 mg or 400 mg single-use vials for intravenous use

References:


This policy and any information contained herein is the property of Blue Cross Blue Shield of Michigan and its subsidiaries, is strictly confidential, and its use is intended for the P&T committee, its members and BCBSM employees for the purpose of coverage determinations.

**Policy History**

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<th>Change Description</th>
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<tr>
<td>1.8</td>
<td>Effective Date: 06/11/2020</td>
<td>Updated policy to not allow use with other biologic medications and add the trial and failure of preferred products statement</td>
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<tr>
<td>1.7</td>
<td>Effective Date: 06/06/2019</td>
<td>Updated for new FDA approved age requirements</td>
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<tr>
<td>1.6</td>
<td>Effective Date: 02/14/2019</td>
<td>Annual Review of Medical Policy</td>
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<tr>
<td>1.5</td>
<td>Effective Date: 02/08/2018</td>
<td>Added SQ formulation</td>
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<tr>
<td>1.4</td>
<td>Effective Date: 07/05/2017</td>
<td>PA added to MAPPO and BCNA</td>
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*The prescribing information for a drug is subject to change. To ensure you are reading the most current information it is advised that you reference the most updated prescribing information by visiting the drug or manufacturer website or http://dailymed.nlm.nih.gov/dailymed/index.cfm.*

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