Benlysta® (belimumab) (Subcutaneous)

I. Length of Authorization

Coverage will be provided for 12 months and may be renewed.

II. Dosing Limits

A. Quantity Limit (max daily dose) [Pharmacy Benefit]:
   - 200 mg/mL single-dose syringe/autoinjector: 1 syringe/autoinjector per week

B. Max Units (per dose and over time) [Medical Benefit]:
   - 200 mg weekly

III. Initial Approval Criteria

- The use of samples and free goods do not qualify as an established clinical response.

Systemic Lupus Erythematosus (SLE) †

- Adult patient (18 years or older): AND
- Patient has a confirmed diagnosis of SLE with at least 4 diagnostic features (see list of diagnostic SLE criteria below)* one of which must include a positive autoantibody test (e.g., anti-nuclear antibody [ANA] greater than laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if tested by ELISA): AND
- Patient has failed to respond adequately to at least two (2) standard therapies such as anti-malarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives (excluding intravenous cyclophosphamide): AND
- Patient has one of the following:
  - Safety of Estrogen in Lupus National Assessment – Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of 6-12
– British Isles Lupus Assessment Group (BILAG) B organ domain score ≥2; AND

• Patient must not have an active infection; AND

• Patient has not received a live vaccine within 30 days before starting or concurrently with Benlysta; AND

• Used in combination with standard therapy (e.g. anti-malarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives); AND

• Patient does not have any of the following exclusion criteria:
  – Severe active central nervous system lupus
  – Severe active lupus nephritis
  – Individuals who are on other biologics or IV cyclophosphamide

† FDA Approved Indication(s)

**Systemic Lupus Erythematosus Diagnostic Criteria**

**Patient must have at least 4 out of 11 diagnostic SLE features:**

1. Malar rash
2. Discoid rash
3. Photosensitivity
4. Oral ulcers
5. Nonerosive arthritis (involving 2 or more peripheral joints)
6. Pleuritis/pericarditis
   • Pleuritis - history of pleuritic pain or rubbing heard by a physician or evidence of pleural effusion
   • Pericarditis - documented by electrocardiogram or rubbing heard by a physician or evidence of pericardial effusion
7. Renal disorder
   • Persistent proteinuria > 0.5 grams/day or > 3+ on urine dipstick
   • Cellular casts (red cell, hemoglobin, granular, tubular, or mixed)
8. Seizures/psychosis
9. Hematologic disorder
   • Hemolytic anemia with reticulocytosis
   • Leukopenia < 4,000/mm$^3$ on ≥ 2 occasions
   • Lymphopenia < 1,500/mm$^3$ on ≥ 2 occasions
   • Thrombocytopenia < 100,000/mm$^3$ in the absence of offending drugs
10. Immunologic disorder
    • Presence of anti-Sm or antiphospholipid antibodies
    • Presence of anti-double-stranded DNA [anti-dsDNA] greater than 2 fold the laboratory reference range if tested by ELISA
11. Positive anti-nuclear antibody [ANA] greater than laboratory reference range

**IV. Renewal Criteria**

Authorizations can be renewed based on the following criteria:

• Patient continues to meet the criteria identified in section III; AND
• Adequate documentation of disease stability and/or improvement as indicated by one or more of the following when compared to pre-treatment baseline:
  - Improvement in the SELENA-SLEDAI score of ≥4 points; OR
  - No new BILAG-A organ domain score or 2 new BILAG-B organ domain scores; OR
  - No worsening (<0.30-point increase) in Physician’s Global Assessment (PGA) score; OR
  - Seroconverted (negative) or had a 20% reduction in autoantibody level; AND

• Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include the following: depression, suicidal thoughts, serious infections, signs or symptoms of progressive multifocal leukoencephalopathy (PML), malignancy, severe hypersensitivity reaction, etc.

V. Dosage/Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dose</th>
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<tbody>
<tr>
<td>Systemic lupus erythematosus (SLE)</td>
<td>200 mg subcutaneously (may be self-administered) once weekly</td>
</tr>
<tr>
<td></td>
<td>• If transitioning from intravenous therapy, administer the first subcutaneous dose 1 to 4 weeks after the last IV dose</td>
</tr>
</tbody>
</table>

VI. Billing Code/Availability Information

Jcode:
• J3590 – Unclassified biologic (applicable to the subcutaneous formulation only)
• C9399 – Unclassified drugs or biologicals (Hospital Outpatient Use ONLY)

NDC:
• 200 mg/mL single-dose syringe/autoinjector: 49401-0088-xx

VII. References


Appendix 1 – Covered Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>ICD-10 Description</th>
</tr>
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<tbody>
<tr>
<td>M32.10</td>
<td>Systemic lupus erythematosus organ or system involvement unspecified</td>
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<tr>
<td>M32.11</td>
<td>Endocarditis in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.12</td>
<td>Pericarditis in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.13</td>
<td>Lung involvement in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.14</td>
<td>Glomerular disease in systemic lupus erythematosus</td>
</tr>
<tr>
<td>M32.15</td>
<td>Tubulo-interstitial nephropathy in systemic lupus erythematosus</td>
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<tr>
<td>M32.19</td>
<td>Other organ or system involvement in systemic lupus erythematosus</td>
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<tr>
<td>M32.8</td>
<td>Other forms of systemic lupus erythematosus</td>
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<tr>
<td>M32.9</td>
<td>Systemic lupus erythematosus, unspecified</td>
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Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: [http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx](http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx). Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD):

<table>
<thead>
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<th>5, 8</th>
<th>NCD/LCD Document(s): L34741</th>
</tr>
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<table>
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<th>Contractor</th>
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<tr>
<td>E (1)</td>
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<td>Noridian Healthcare Solutions, LLC</td>
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<td>F (2 &amp; 3)</td>
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<td>Noridian Healthcare Solutions, LLC</td>
</tr>
<tr>
<td>5</td>
<td>KS, NE, IA, MO</td>
<td>Wisconsin Physicians Service Insurance Corp (WPS)</td>
</tr>
<tr>
<td>6</td>
<td>MN, WI, IL</td>
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<td>H (4 &amp; 7)</td>
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<tr>
<td>8</td>
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<td>N (9)</td>
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<td>First Coast Service Options, Inc.</td>
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<td>Novitas Solutions, Inc.</td>
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<td>K (13 &amp; 14)</td>
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<td>15</td>
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