RXADVANCE
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Clinical Policy Title:	belimumab
Policy Number:	RxA.37
Drug(s) Applied:	Benlysta®
Original Policy Date:	03/06/2020
Last Review Date:	12/07/2020
Line of Business Policy Applies to:	All lines of business

Background

Belimumab (Benlysta®) is B-lymphocyte stimulator specific inhibitor. It 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.

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

Dosing Information

Drug Name	Indication	Dosing Regimen	Maximum Dose
belimumab (Benlysta®)	SLE	IV (pediatrics and adults): 10 mg/kg at 2-week intervals for the first 3 doses and at 4-week intervals thereafter SC (adults only): 200 mg once weekly Transition from IV to SC therapy (adults): Administer first SC dose 1 to 4 weeks after the last IV dose	IV: 10 mg/kg/dose SC: 200 mg/week

Dosage Forms

- Single-dose vial: 120 mg and 400 mg lyophilized powder for reconstitution
- Single-dose prefilled autoinjector/syringe: 200 mg/mL

Clinical Policy

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

I. Initial Approval Criteria

A. Systemic Lupus Erythematosus (must meet all):

1. Diagnosis of SLE;
2. Prescribed by or in consultation with a rheumatologist;
3. Age 5 years of age or older;
4. Documentation confirms that member is positive for an SLE autoantibody (e.g., antinuclear antibody (ANA), anti-double-stranded DNA (anti-dsDNA), anti-Smith (antiSm), anti-ribonucleoprotein (anti-RNP), anti-Ro/SSA, anti-La/SSB, antiphospholipid antibody);
5. Currently receiving standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
6. Request meets one of the following (a or b):
   a. Adults (18 years of age or older):
      i. IV: Dose does not exceed 10 mg/kg/dose at 2-week intervals for the first 3 doses and at 4-week intervals thereafter;
      ii. SC: 200 mg/week;
   b. Pediatrics (5 years of age or older): Dose does not exceed 10 mg/kg/dose IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.

Approval Duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Systemic Lupus Erythematosus (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or member has previously met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. Currently receiving standard therapy for SLE that includes one or more of the following agents, unless all agents are contraindicated: glucocorticoids (e.g., prednisone), antimalarial (e.g., hydroxychloroquine or chloroquine), non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate);
4. If request is for a dose increase, request meets one of the following (a or b):
   a. Adults (18 years of age or older):
      i. IV: Dose does not exceed 10 mg/kg/dose at 2-week intervals for the first 3 doses and at 4-week intervals thereafter;
      ii. SC: 200 mg/week;
   b. Pediatrics (5 years of age or older): Dose does not exceed 10 mg/kg/dose IV at 2-week intervals for the first 3 doses and at 4-week intervals thereafter.

Approval Duration
Commercial: 12 months
Medicaid: 6 months

III. Appendices

APPENDIX A: Abbreviation/Acronym Key
ANA: Anti-nuclear antibody
Anti-dsDNA: Anti-double-stranded DNA
Anti-Sm: Anti-Smith

SLE: Systemic lupus erythematosus
FDA: Food and Drug Administration
DNA: Deoxyribonucleic acid

APPENDIX B: Therapeutic Alternatives
Below are suggested therapeutic alternatives based on clinical guidance. Please check drug formulary for preferred agents and utilization management requirements.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glucocorticoids (e.g., prednisone)	Varies	Varies
antimalarial agents (e.g., hydroxychloroquine, chloroquine)	Varies	Varies
non-biologic immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

APPENDIX C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Previous anaphylaxis to belimumab.

- Boxed Warning(s):
  - None.

APPENDIX D: General Information
Autoantibody positive versus negative SLE
Only one of the five Benlysta® pivotal trials included patients with autoantibody negative SLE; no significant differences between any of the Benlysta® groups and the placebo group were observed. However, on further analysis Benlysta® appeared to offer benefit to a subgroup of autoantibody positive patients. Benlysta's efficacy was confirmed in the remaining four trials which included only autoantibody positive patients. Because of the apparent lack of efficacy in autoantibody negative patients and because the FDA has approved Benlysta® in only autoantibody positive patients, Benlysta® coverage will not be authorized for patients with autoantibody negative SLE.

References

1. Benlysta Prescribing Information. Research Triangle Park, NC: GlaxoSmithKline; Sep 2020. Available at http://www.benlysta.com. Accessed October 05, 2020.
2. Fanouriakis A, Kostopoulou M, Alunno A, et al. 2019 update of the EULAR recommendations for the management of systemic lupus erythematosus. Ann Rheum Dis 2019;0:1–10. doi:10.1136/annrheumdis-2019-215089. Accessed October 05, 2020.
3. Petri M, Orbai AM, Alarcón GS, et al. Derivation and validation of the Systemic Lupus International Collaborating Clinics classification criteria for systemic lupus erythematosus. Arthritis Rheum 2012; 64:2677. Accessed October 05, 2020.
4. Gordon C, Amissah-Arthur MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. Rheumatology 2018;57:e1-e45. doi:10.1093/rheumatology/kex286.

Accessed October 05, 2020

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy was reviewed: 1. Policy title table was updated: Line of business policy applies was updated to All lines of business. 2. Continued therapy criteria II.A.1 was rephrased to "Currently receiving medication that has been authorized by RxAdvance…". 3. Approval duration was updated (HIM removed). 4. References were reviewed and updated.	10/05/2020	12/07/2020