Field Name	Field Description
Prior Authorization Group Description	**Benlysta (belimumab)**
Drugs	Benlysta (belimumab)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, the Drug Package Insert, and/or per the standard of care guidelines
Exclusion Criteria	Severe active central nervous system lupus
Required Medical Information	See "other criteria"
Age Restrictions	Must be at least 5 years of age
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist or nephrologist
Coverage Duration	If all the criteria are met initial authorization requests may be approved for up to 6 months. Reauthorization requests may be approved for up to 12 months.
Other Criteria	**Initial Authorization**: • Active systemic lupus erythematosus (SLE) o Provider attestation that the patient is positive for autoantibodies (or antinuclear antibodies or anti–double-stranded DNA [anti-dsDNA] antibodies) o The member has tried and failed both of the following (or contraindication/inability to use these medications): ▪ Hydroxychloroquine ▪ One other immunosuppressant [e.g., methotrexate, azathioprine, calcineurin inhibitors or mycophenolate] • Active lupus nephritis o Provider attestation of diagnosis confirmed by kidney biopsy o The member has tried and failed, or has a medical reason for not using, both of the following ▪ Cyclophosphamide or tacrolimus ▪ Mycophenolate • Provider states the member will not be receiving concomitant therapy with the following: o B-cell targeted therapy including (but not limited to) rituximab o Interferon receptor antagonist, type 1 including (but not limited to) Saphnelo (anifrolumab) • Dosing is appropriate per labeling **Criteria for Reauthorization**: • Documentation or provider attestation of positive clinical response as indicated by one of the following:

Revision/Review Date: 1/2023	○ Fewer flares that required steroid treatment ○ Lower average daily oral prednisone dose ○ Improved daily function either as measured through a validated functional scale or through improved daily performance documented at clinic visits ○ Sustained improvement in laboratory measures of lupus activity • Dosing is appropriate per labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**