Effective: January 1, 2023

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

<table>
<thead>
<tr>
<th>Applies to:</th>
<th>Yes ☒ No ☐</th>
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<tbody>
<tr>
<td><strong>Commercial Products</strong></td>
<td></td>
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<tr>
<td>☐ Harvard Pilgrim Health Care Commercial products; Fax 617-673-0988</td>
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</tr>
<tr>
<td>☐ Tufts Health Plan Commercial products; Fax 617-673-0988</td>
<td>CareLink™ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization</td>
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<tr>
<th>Public Plans Products</th>
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<tbody>
<tr>
<td>☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 617-673-0988</td>
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<tr>
<td>☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 617-673-0988</td>
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<tr>
<td>☐ Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 617-673-0988</td>
<td>☒ Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 617-673-0956</td>
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  *The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists. |
| ☒ Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0956 | ☒ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0956 |
| ☒ Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0956 | ☒ Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0956 |

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

**Overview**

**Food and Drug Administration (FDA) Approved Indications:**

Benlysta (belimumab) is a B-lymphocyte stimulator (BLyS)-specific inhibitor indicated for the treatment of:
- Patients aged 5 years and older with active, autoantibody-positive, systemic lupus erythematosus (SLE) who are receiving standard therapy.
- Patients aged 5 years and older with active lupus nephritis who are receiving standard therapy.

**Clinical Guideline Coverage Criteria**

The Plan may authorize coverage of Benlysta (belimumab) for Members when all of the following criteria are met:

**Active Lupus Nephritis**

1. Diagnosis of Active Lupus Nephritis that has been confirmed by urine/blood tests or kidney biopsy

2. Member is 5 years of age or older

3. The prescribing physician is a rheumatologist or nephrologist or recommended in consult with a rheumatologist or nephrologist

**Systemic Lupus Erythematosus**
1. Documented diagnosis of active, autobody positive systemic lupus erythematosus (SLE) AND
2. The Member is 5 years of age or older AND
3. The prescribing physician is a rheumatologist or is recommended in consult with a rheumatologist

Limitations

- For the treatment of systemic lupus erythematosus (SLE), Benlysta (belimumab) will not be approved in the following instances
  - For Members with severe active central nervous system lupus
  - For Members who are autoantibody negative
  - For use in combination with other biologic therapies used to treat Lupus

Codes

The following code(s) require prior authorization:

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>J0490</td>
<td>Injection, belimumab, 10 mg</td>
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References:


Approval And Revision History

- September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)
- September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.