| Reference number |
| --- |
| 2502-A |

# Aetna Medicare Part B Drug Criteria

## Benlysta

**This policy is for Aetna Medicare members. Find the Aetna Commercial Medical Drug Criteria.**

**For Aetna Medicare members, National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) will be applied to Part B drug requests when applicable. Aetna Medicare Part B Drug Criteria documents will be used in the absence of an NCD and LCD.**

## POLICY

### Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

| Brand Name | Generic Name |
| --- | --- |
| Benlysta | belimumab |

### Indications

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met, the member has no exclusions to the prescribed therapy, and the drug or biological is usually not self-administered. The criteria outlined in this policy is only applicable to drugs not usually self-administered and are furnished incident to a physician's service. Requests for drugs on a region's self-administered drug list are not covered. Members enrolled in Medicare Part D may seek coverage under their Medicare Part D plan.

#### FDA-Approved Indications[1]

Benlysta is indicated for the treatment of:

- Patients 5 years of age and older with active systemic lupus erythematosus (SLE) who are receiving standard therapy
- Patients 5 years of age and older with active lupus nephritis who are receiving standard therapy

#### Limitations of Use

The efficacy of Benlysta has not been evaluated in patients with severe active central nervous system (CNS) lupus. Use of Benlysta is not recommended in this situation.

All other indications will be assessed on an individual basis. Submissions for indications other than those listed in this criteria should be accompanied by supporting evidence from Medicare approved compendia.

## Documentation

The following documentation must be available, upon request, for all submissions:

### Initial requests

Medical records (e.g., chart notes, lab reports) documenting the presence of autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins), or kidney biopsy supporting diagnosis (where applicable).

### Continuation requests

Medical records (e.g., chart notes, lab reports) documenting disease stability or improvement.

## Exclusions

Coverage will not be provided for members with any of the following exclusions:

- Severe active central nervous system (CNS) lupus (including seizures that are attributed to CNS lupus, psychosis, organic brain syndrome, cerebritis, or CNS vasculitis requiring therapeutic intervention before initiation of belimumab) in a member initiating therapy with Benlysta.
- Member is using Benlysta in combination with other biologics.

## Coverage Criteria

### Systemic lupus erythematosus (SLE)[1-4]

Authorization of 12 months may be granted for treatment of active SLE when both of the following criteria are met:

- Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins)
- The member meets either of the following criteria:
  - The member is receiving standard treatment for SLE with any of the following (alone or in combination):
    - Glucocorticoids (e.g., prednisone, methylprednisolone, dexamethasone)
    - Antimalarials (e.g., hydroxychloroquine)
    - Immunosuppressants (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)
  - The member has a clinical reason to avoid treatment with a standard treatment regimen.

### Active lupus nephritis[1-5]

Authorization of 12 months may be granted for treatment of active lupus nephritis when both of the following criteria are met:

- Prior to initiating therapy, the member is positive for autoantibodies relevant to SLE (e.g., ANA, anti-ds DNA, anti-Sm, antiphospholipid antibodies, complement proteins) or lupus nephritis was confirmed on kidney biopsy.
- Member is receiving standard therapy regimen (e.g., cyclophosphamide, mycophenolate mofetil, azathioprine, corticosteroids) or has a clinical reason to avoid treatment with a standard therapy regimen.

## Continuation of Therapy

All members (including new members) requesting authorization for continuation of therapy must be currently receiving therapy with the requested agent.

Authorization for 12 months may be granted when all of the following criteria are met:

- The member is currently receiving therapy with the requested medication.
- The requested medication is being used to treat an indication listed in the coverage criteria.
- The member is receiving benefit from therapy. Benefit is defined as disease stability or improvement.

## Summary of Evidence

The contents of this policy were created after examining the following resources:

- The prescribing information for Benlysta.
- The available compendium
  - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
  - Micromedex DrugDex
  - American Hospital Formulary Service- Drug Information (AHFS-DI)
  - Lexi-Drugs
  - Clinical Pharmacology
- 2023 Update of the EULAR Recommendations for the Management of Systemic Lupus Erythematosus
- 2019 European League Against Rheumatism/American College of Rheumatology (ACR) classification criteria for systemic lupus erythematosus
- Kidney Disease: Improving Global Outcomes (KDIGO) 2024 Clinical Practice Guideline for the Management of Glomerular Diseases
- The British Society for Rheumatology guideline for the management of systemic lupus erythematosus
- Derivation and Validation of Systemic Lupus International Collaborating Clinics (SLICC) Classification Criteria for Systemic Lupus Erythematosus

After reviewing the information in the above resources, the FDA-approved indications listed in the prescribing information for Benlysta are covered.

## Explanation of Rationale

Support for FDA-approved indications can be found in the manufacturer's prescribing information.

The content of the exclusions can be found in the prescribing information.

The British Society for Rheumatology report that ANAs are present in about 95% of SLE patients. If the test for ANAs is negative, there is a low clinical probability of a member having SLE. The presence of anti-dsDNA antibodies, low complement levels or anti-Smith (Sm) antibodies are highly predictive of a diagnosis of SLE in patients with relevant clinical features. Anti-Ro/La and anti-RNP antibodies are less-specific markers of SLE as they are found in other autoimmune rheumatic disorders as well as SLE.

The SLICC group devised evidence-based classification criteria for lupus. These criteria introduced a requirement for at least one clinical and one immunological criterion and two others from an expanded list of items compared with the ACR criteria. They also allowed biopsy-proven lupus nephritis in the presence of ANA or anti-dsDNA antibodies to be classified as lupus, without the need for other criteria. These classification criteria may be used to aid diagnosis.

The EULAR/ACR classification criteria for SLE require ANA antibodies ≥ 1:80 on HEp-2 cells or an equivalent positive test and a classification threshold score of ≥ 10. The classification criteria should not be used as diagnostic criteria. Testing by immunofluorescence on HEp-2 cells or a solid-phase ANA screening immunoassay with at least equivalent performance is highly recommended.

According to the 2023 update of the EULAR recommendations for the management of systemic lupus erythematosus, the goal of treatment should be remission or low disease activity and prevention of flares in all organs. Hydroxychloroquine is recommended for all patients, unless contraindicated. Glucocorticoids (GC), if needed, can be used at doses and route of administration that depend on the type and severity of organ involvement and should be reduced to maintenance dose of less than or equal to 5 mg/day (prednisone equivalent). In patients not responding to hydroxychloroquine (alone or in combination with GC) or patients unable to reduce GC below doses acceptable for chronic use, addition of immunomodulating/immunosuppressive agents such as methotrexate, azathioprine, or mycophenolate and/or biological agents (e.g., belimumab or anifrolumab) should be considered. In patients with organ-threatening or life-threatening disease, cyclophosphamide should be considered.

## References

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4. Rovin BH, Adler SG, Barratt J, et al. Kidney Disease: Improving Global Outcomes (KDIGO) Lupus nephritis Work Group. KDIGO 2024 Clinical Practice Guideline for the Management of Lupus Nephritis. Kidney Int. 2024; 105(15):S1-S69.
5. Gordon C, Amissah-Arthru MB, Gayed M, et al. The British Society for Rheumatology guideline for the management of systemic lupus erythematosus in adults. Rheumatology (Oxford). 2018; 57(1):e1-e45.
6. Petri M, Orbai A-M, Alarcon GS, et al. Derivation and Validation of Systemic Lupus International Collaborating Clinics (SLICC) Classification Criteria for Systemic Lupus Erythematosus. Arthritis Rheum. 2012; 64:2677-2686. URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3409311/. Accessed January 22, 2025.
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15. Self-Administered Drug Exclusion List: Medical Policy Article (A53022). Available at: https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx. Accessed January 22, 2025.

## CPT Codes / HCPCS Codes / ICD-10 Codes

| Code | Description |
| --- | --- |
| **Other CPT codes related to the Med B drug criteria:** | |
| 96401 | Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic |
| 96413 – 96417 | Chemotherapy administration, intravenous infusion technique |
| **HCPCS codes covered if selection criteria are met:** | |
| J0490 | Injection, belimumab, 10 mg |
| **Other HCPCS codes related to the Med B drug criteria**: | |
| Hydroxychloroquine, naproxen-No specific code: | |
| J1010 | Injection, methylprednisolone acetate, 1 mg |
| J1100 | Injection, dexamethasone sodium phosphate, 1 mg |
| J1741 | Injection, ibuprofen, 100 mg |
| J2919 | Injection, methylprednisolone sodium succinate, 5 mg |
| J7500 | Azathioprine, oral, 50 mg |
| J7501 | Azathioprine, parenteral, 100 mg |
| J7502 | Cyclosporine, oral, 100 mg |
| J7509 | Methylprednisolone oral, per 4 mg |
| J7512 | Prednisone, immediate release or delayed release, oral, 1 mg |
| J7514 | Mycophenolate mofetil (myhibbin), oral suspension, 100 mg |
| J7515 | Cyclosporine, oral, 25 mg |

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| J7516 | Injection, cyclosporine, 250 mg |
| J7517 | Mycophenolate mofetil, oral, 250 mg |
| J7519 | Injection, mycophenolate mofetil, 10 mg |
| J8530 | Cyclophosphamide; oral, 25 mg |
| J8540 | Dexamethasone, oral, 0.25 mg |
| J8541 | Dexamethasone (hemady), oral, 0.25 mg |
| J8610 | Methotrexate; oral, 2.5 mg |
| J8611 | Methotrexate (jylamvo), oral, 2.5 mg |
| J8612 | Methotrexate (xatmep), oral, 2.5 mg |
| J9071 | Injection, cyclophosphamide (auromedics), 5 mg |
| J9072 | Injection, cyclophosphamide (avyxa), 5 mg |
| J9073 | Injection, cyclophosphamide (dr. reddy's), 5 mg |
| J9074 | Injection, cyclophosphamide (sandoz), 5 mg |
| J9075 | Injection, cyclophosphamide, not otherwise specified, 5 mg |
| J9076 | Injection, cyclophosphamide (baxter), 5 mg |
| J9255 | Injection, methotrexate (accord) not therapeutically equivalent to j9250 and j9260, 50 mg |
| J9260 | Injection, methotrexate sodium, 50 mg |
| **ICD-10 codes covered if selection criteria are met:** | |
| M32.0-M32.9 | Systemic lupus erythematosus (SLE) [active] [active lupus nephritis] |
| **ICD-10 codes not covered for indications listed in the Med B drug criteria:** | |
| G04.00-G04.91 | Encephalitis, myelitis and encephalomyelitis |
| G05.3-G05.4 | Encephalitis, myelitis and encephalomyelitis in diseases classified elsewhere |
| G40.001-G40.C19 | Epilepsy and recurrent seizures |
| F07.0-F07.9 | Personality and behavioral disorders due to known physiological condition |
| F20.81-F29 | Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders |

**Revision History**

| Date | Version | Update | Revisions |
| --- | --- | --- | --- |
| 01/01/2024 | 2023 | New Criteria | Policy effective. |
| 12/01/2024 | 2024a | Criteria Change | For exclusions criteria, removed "within 60 days" timeframe prior to initiation of requested drug under examples of severe active CNS lupus. |
| 09/01/2025 | 2025 | Criteria Change | Removed "stable" from standard treatment initial criteria for systemic lupus erythematosus and active lupus nephritis. Removed NSAIDs as a standard treatment option for systemic lupus erythematosus. |

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.