



STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Christina Mullins, MA
Acting Cabinet Secretary

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Commissioner

**Office of Pharmacy Services
Prior Authorization Criteria
Benlysta® (Belimumab)**

[Prior Authorization Request Form](#)

Benlysta is indicated for the treatment of adults and children ≥ 5 years of age with active, autoantibody-positive systemic lupus erythematosus (SLE) who are receiving standard therapy or for the treatment of adults and children ≥ 5 years of age active lupus nephritis who are receiving standard therapy.

Prior authorization requests for Benlysta may be approved if the following criteria are met:

1. Documented diagnosis of active systemic lupus erythematosus (SLE) or Lupus Nephritis; **AND**
2. The patient is positive for autoantibodies (anti-nuclear antibody (ANA) and/or anti-double-stranded DNA (anti-dsDNA); **AND**
3. The patient must be within the age range as recommended by the FDA label and indication; **AND**
4. Prescribed by, or in consultation with, a rheumatologist or nephrologist; **AND**
5. **For SLE:** The patient has had a documented inadequate response or intolerance to at least **TWO** of the following agents: non-steroidal anti-inflammatory drugs (NSAIDs), hydroxychloroquine, corticosteroids, methotrexate, azathioprine, cyclosporine, or mycophenolate; **AND**
6. **For LN:** Patient has failed to respond adequately to standard therapies including corticosteroids **AND** cyclophosphamide, mycophenolate mofetil or azathioprine.

Initial approval will be granted for 3 months.

NOTE: Use is not recommended in patients with severe active lupus nephritis, severe active CNS lupus, or in combination with other biologics, including B-cell targeted therapies. Use of Benlysta should be avoided and is not recommended in these situations.

CONTINUATION OF THERAPY CRITERIA: Clinical documentation must be submitted documenting stability/reduction in disease activity OR a reduction in corticosteroid dose.

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