Lupus Treatments

Included Products: Benlysta (belimumab), Saphnelo (anifrolumab-fnia)

IV is nonformulary for outpatient benefit. PA required on medical benefit.

Created: 09/19/2011 *Revised:* 05/11/2023 *Reviewed:* 05/11/2023 *Updated:* 06/01/2023

All Diagnoses

Initial Criteria		If yes	If no
1.	Is the requested medication being prescribed by or in consultation with an appropriate specialist? a. Systemic lupus erythematosus (SLE): rheumatologist b. Lupus nephritis (LN): nephrologist or rheumatologist	Continue to #2.	Do not approve.
2.	Does the member have a diagnosis of active, autoantibody-positive systemic lupus erythematosus (SLE)?	Continue to #3.	Do not approve.
3.	Does the member have severe active central nervous system lupus?	Do not approve.	Continue to #4.
4.	Is the product use supported in the age and indication of the member?	Continue to #5.	Do not approve.
5.	Is the treatment being used along with another lupus-specific treatment (belimumab, anifrolumab, or voclosporin)?	Do not approve. Combination therapy is not supported.	Continue to #6.

Lupus Nephritis

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of biopsy-proven lupus nephritis Class III, IV, and/or V?	Continue to #2.	Do not approve.

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2.	Does the member currently have active disease while on standard therapy? a. Steroids, AND b. Immunosuppressant(s)	Continue to #3.	Do not approve.
3.	Approve for 6 months.		
Renewal Criteria		**If yes**	**If no**
1.	Is the member continuing on at least one standard therapy: corticosteroids or immunosuppressants?	Continue to #2.	Do not approve.
2.	Has the member had a documented response to therapy, such as stabilization of labs (eGFR), improvement in function, decrease in corticosteroid dose, or decrease in the number of exacerbations?	Continue to #3.	Do not approve.
3.	Approve for 12 months.		

Systemic Lupus Erythematosus

Initial Criteria		If yes	If no
1.	Does the member have moderate to severe refractory SLE?	Continue to #2.	Do not approve.
2.	Has the member failed all of the following (alone or in combination)? a. Corticosteroids b. Hydroxychloroquine c. Immunosuppressants (e.g. cyclophosphamide, cyclosporine, tacrolimus, leflunomide, azathioprine, mycophenolate, and methotrexate)	Continue to #3.	Do not approve.
3.	Is the member currently on standard therapy? a. Corticosteroids, AND b. Hydroxychloroquine, or immunosuppressants if hydroxychloroquine is contraindicated	Continue to #4.	Do not approve.
4.	Is the member currently on another biologic?	Do not approve.	Continue to #5.
5.	Approve for 6 months.		

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Renewal Criteria		If yes	If no
1.	Is the member continuing on at least one standard therapy: corticosteroids, hydroxychloroquine, or immunosuppressants?	Continue to #2.	Do not approve.
2.	Has the member had a documented response to therapy, such as reduction in SELENA-SLEDAI score or BILAG index, improvement in function, decrease in corticosteroid dose, or decrease in the number of exacerbations?	Continue to #3.	Do not approve.
3.	Approve for 12 months.		