Clinical Policy: Obeticholic Acid (Ocaliva)

Reference Number: CP.PHAR.287
Effective Date: 11.16
Last Review Date: 8.24
Line of Business: Commercial, HIM, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Obeticholic acid (Ocaliva®) is a farnesoid X receptor agonist.

FDA Approved Indication(s)

Ocaliva is indicated for the treatment of adult patients with primary biliary cholangitis (PBC) (without cirrhosis or with compensated cirrhosis who do not have evidence of portal hypertension) either in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA

This indication is approved under accelerated approval based on a reduction in alkaline phosphatase (ALP). An improvement in survival or disease-related symptoms has not been established. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Ocaliva is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Primary Biliary Cholangitis (must meet all)**:**

1. Diagnosis of PBC;
2. Prescribed by or in consultation with a hepatologist or gastroenterologist;
3. Age ≥ 18 years;
4. One of the following (a or b):
   a. Member does not have cirrhosis;
   b. Member has compensated cirrhosis without evidence of portal hypertension (e.g., ascites, gastroesophageal varices, or persistent thrombocytopenia);
5. Failure (as evidenced by sustained elevation in ALP ≥ 1.67 times the upper limit of normal) of ≥ 12 month trial of UDCA (ursodiol) at a dose of ≥ 13 mg/kg/day, unless contraindicated or clinically significant adverse effects are experienced;
6. Prescribed in combination with UDCA, unless contraindicated or clinically significant adverse effects are experienced;
7. Dose does not exceed both of the following (a and b):
   a. 10 mg per day;
   b. 1 tablet per day.

Approval duration: 6 months

B. Other diagnosis/indications (must meet 1 or 2):
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Primary Biliary Cholangitis (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B)*;
2. Member is responding positively to therapy as evidenced by one of the following (a or b):
   a. Initial reauthorization: reduction in ALP level from pretreatment level;
   b. Subsequent reauthorization: continued reduction or maintenance of initial reduction in ALP level;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 10 mg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

AASLD: American Association for the Study of Liver Diseases
ALP: alkaline phosphatase
FDA: Food and Drug Administration
PBC: primary biliary cholangitis
UDCA: ursodeoxycholic acid
ULN: upper limit of normal

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ursodiol (Urso®, Urso Forte®, Actigall®)	13-15 mg/kg/day PO in 2-4 divided doses	15 mg/kg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Decompensated cirrhosis (e.g., Child-Pugh Class B or C) or a prior decompensation event.
  - Compensated cirrhosis with evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).
  - Complete biliary obstruction.

- Boxed warning(s):
  - Hepatic decompensation and failure, sometimes fatal or resulting in liver transplant, have been reported with Ocaliva treatment in PBC patients with either compensated or decompensated cirrhosis.
  - Ocaliva is contraindicated in PBC patients with decompensated cirrhosis, a prior decompensation event, or with compensated cirrhosis who have evidence of portal hypertension.
  - Permanently discontinue Ocaliva in patients who develop laboratory or clinical evidence of hepatic decompensation; have compensated cirrhosis and develop evidence of portal hypertension; or experience clinically significant hepatic adverse reactions while on treatment.

Appendix D: General Information

- According to the AASLD Primary Biliary Cirrhosis 2018 practice guidelines, UDCA dosed at 13-15 mg/kg/day orally is recommended for all patients with PBC who have abnormal liver enzyme values regardless of histological stage. Improvement in liver tests will be seen within a matter of a few weeks and 90% of the improvement usually occurs within 6-9 months. The eligibility criteria in the Ocaliva efficacy trial required enrolled patients to have a minimum 12 month history of taking UDCA.
- In the PBC clinical trial, response was defined as a composite of three criteria: ALP less than 1.67-times the ULN, total bilirubin less than or equal to ULN, and an ALP decrease of at least 15%. The ULN for ALP was defined as 118 U/L for females and 124 U/L for males. The ULN for total bilirubin was defined as 1.1 mg/dL for females and 1.5 mg/dL for males.
- A diagnosis of PBC can be established when two of the following three criteria are met:
  - Alkaline phosphatase (ALP) is elevated above the upper limit of normal as defined by normal laboratory references values;
  - Positive anti-mitochondrial antibodies (AMA) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative;
  - Histologic evidence of PBC from a liver biopsy.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PBC	5 mg PO QD titrated after 3 months to 10 mg PO QD based on efficacy and tolerability	10 mg/day

VI. Product Availability

Tablets: 5 mg, 10 mg

VII. References

1. Ocaliva Prescribing Information. New York, NY: Intercept Pharmaceuticals, Inc.; May 2022. Available at: https://ocaliva.com/. Accessed May 10, 2024.

2. Lindor KD, Bowlus CL, Boyer J, et al. Primary biliary cholangitis: 2018 practice guidance from the American Association for the Study of Liver Diseases (AASLD). Hepatology. 2018; 0(0): 1-26. Available at: https://journals.lww.com/hep/fulltext/2019/01000/primary_biliary_cholangitis__2018_practice.32.aspx. Accessed May 23, 2024.
3. Lindor KD, Bowlus CL, Boyer J, et al. Primary biliary cholangitis: 2021 practice guidance update from the American Association for the study of liver diseases. Hepatology. 2022 April;75(4):1012-1013.
4. European Association for the Study of the Liver (EASL). EASL clinical practice guidelines: the diagnosis and management of patients with primary biliary cholangitis. J Hepatology. 2017;67:145-72.
5. Louie JS, Grandhe S, Matsukuma K and Bowlus CL. Primary biliary cholangitis: a brief overview. Clinical liver disease. 2020; 15(3):100-104.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added preemptive criteria for the pending FDA approval of NASH indication; added HIM line of business; for PBC, revised LFT elevations to ALP at least 1.67xULN.	03.10.20	05.20
3Q 2020 annual review: no significant changes; references reviewed and updated.	05.07.20	08.20
3Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	04.13.21	08.21
Disclaimer added for NASH preemptive criteria that they should only be used after this indication is FDA approved.	02.09.22	
3Q 2022 annual review: no significant changes; added "without cirrhosis or with compensated cirrhosis who do not have evidence of portal hypertension" to indication and initial criteria per PI; removal of Child Pugh B/C dosing as it is contraindicated per PI; references reviewed and updated.	04.13.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.20.22	
3Q 2023 annual review: no significant changes; added examples of evidence of portal hypertension; references reviewed and updated.	04.11.23	08.23
Removal of NASH preemptive criteria from policy.	09.12.23	11.23
3Q 2024 annual review: no significant changes; references reviewed and updated.	05.10.24	08.24

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical

policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.