

## **Clinical Policy: Obeticholic acid (Ocaliva)**

Reference Number: CP.PHAR.287

Effective Date: 11.16

Last Review Date: 08.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Obeticholic acid (Ocaliva<sup>®</sup>) is a farnesoid X receptor agonist.

### **FDA Approved Indication(s)**

Ocaliva is indicated for the treatment of primary biliary cholangitis (PBC) in combination with ursodeoxycholic acid (UDCA) in adults with an inadequate response to UDCA, or as monotherapy in adults unable to tolerate UDCA.

### **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<sup>®</sup> 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 gastrointestinal (GI) specialist;
3. Age  $\geq$  18 years;
4. Failure (as evidenced by sustained elevation in liver function tests) of  $\geq$  12 month trial of UDCA (ursodiol) at a dose of  $\geq$  13 mg/kg/day, unless contraindicated or clinically significant adverse effects are experienced;
5. Prescribed in combination with UDCA, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 10mg/day (1 tablet/day).

**Approval duration: 6 months**

### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

## **II. Continued Therapy**

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

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy as evidenced by one of the following (a or b):
    - a. Initial reauthorization: reduction in alkaline phosphatase (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 10 mg/day (1 tablet/day).
- Approval duration: 12 months**

**B. Other diagnoses/indications (1 or 2):**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 6 months (whichever is less); or**

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial 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 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  
 GI: gastrointestinal  
 ICER: Institute for Clinical and Economic Review

NASH: non-alcoholic steatohepatitis  
 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.*

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

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

*Appendix C: Contraindications*

- Complete biliary obstruction

*Appendix D: General Information*

- Ocaliva is approved under accelerated approval based on a reduction in 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.
- Ocaliva is being evaluated for the treatment of non-alcoholic steatohepatitis (NASH). Results of a phase II trial are available. A Phase III trial is ongoing. Based on an ICER (Institute for Clinical and Economic Review) review, obeticholic acid as an off-label treatment for adults with NASH with fibrosis is not currently recommended. The limited evidence was deemed insufficient based on uncertainty regarding the long-term clinical effects of changes in surrogate endpoints and conflicting physiological outcomes while taking the drug (e.g., insulin resistance in one trial versus another trial).
- According to the AASLD Primary Biliary Cirrhosis 2009 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.
- Ocaliva prescribing information includes a black box warning for hepatic decompensation and failure (in some cases fatal) in incorrectly dosed PBC patients with Child-Pugh Class B or C or decompensated cirrhosis. The recommended starting dose is 5 mg once weekly for these patients titrated to 10mg twice weekly (at least 3 days apart) based on response and tolerability.
- 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.

**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  Dose adjustments required for Child-Pugh Class B/C or patients with prior decompensation event	10 mg/day

**VI. Product Availability**

Tablets: 5 mg, 10 mg

**VII. References**

1. Ocaliva Prescribing Information. New York, NY: Intercept Pharmaceuticals, Inc.; February 2018. Available at <https://ocaliva.com/>. Accessed May 8, 2018.

2. Lindor, KD, Gershwin ME, Poupon R et al. AASLD Practice Guidelines: Primary biliary cirrhosis. *Hepatology*. 2009; 50(1): 291-308.
3. 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.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created.	10.16	11.16
Age added; safety criteria applied according to the safety guidance discussed at CPAC and endorsed by Centene Medical Affairs.	09.17	11.17
3Q 2018 annual review: Policies combined for Commercial and Medicaid lines of business; added prescriber requirement; removed criteria confirming diagnosis; modified UDCA monotherapy trial duration to 12 months from 6 months based on Ocaliva package labeling and treatment guideline recommendations; references reviewed and updated	05.08.18	08.18

**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.

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**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.

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