Clinical Policy: Cholic Acid (Cholbam)

Reference Number: ERX.SPA.274
Effective Date: 12.01.18
Last Review Date: 11.22
Line of Business: Commercial, Medicaid

Revision Log

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

Description
Cholic acid (Cholbam®) is a bile acid.

FDA Approved Indication(s)
Cholbam is indicated for:

- Treatment of bile acid synthesis disorders due to single enzyme defects (SEDs)
- Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption

Limitation(s) of use: The safety and effectiveness of Cholbam on extrahepatic manifestations of bile acid synthesis disorders due to SEDs or PDs including Zellweger spectrum disorders have not been established.

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Cholbam is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Bile Acid Synthesis Disorders or Peroxisomal Disorders (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. Bile acid synthesis disorders due to SEDs;
   b. PDs, including Zellweger spectrum disorders;
2. Diagnosis is confirmed by at least one of the following (a or b):
   a. An abnormal urinary bile acid consistent with a bile acid synthesis or Zellweger spectrum disorder as confirmed by fast atom bombardment ionization – mass spectrometry (FAB-MS) analysis;
   b. Molecular genetic testing consistent with diagnosis (e.g., biallelic pathogenic variants in ABCD3, AKR1D1, AMACR, HSD3B7, CYP27A1, CYP7B, or PEX genes);
3. Prescribed by or in consultation with a hepatologist, gastroenterologist, or metabolic disease specialist;
4. Documentation of current (within the last 30 days) liver function test results;
5. Dose does not exceed 17 mg/kg per day.

Approval duration: 3 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Bile Acid Synthesis Disorders or Peroxisomal Disorders (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;
2. Member is responding positively to therapy as evidenced by improvement in liver function tests with both of the following (a and b)
   a. Alanine transaminase (ALT) or aspartate transaminase (AST) values reduced to < 50 U/L or baseline levels reduced by 80%;
   b. Total bilirubin values reduced to ≤ 1 mg/dL;
3. If request is for a dose increase, new dose does not exceed 17 mg/kg per day.

Approval duration:
Commercial – Length of Benefit
Medicaid – 12 months

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FAB-MS: fast atom bombardment ionization – mass spectrometry
FDA: Food and Drug Administration
PDs: peroxisomal disorders
SEDs: single enzyme defects

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

None reported

Appendix D: General Information

- Bile acid synthesis disorders and PDs may be diagnosed with either genetic testing or urine bile acid profile by FAB-MS. Bile acid testing by FAB-MS assesses the phenotypic, biochemical response to a genetic disorder.
- Treatment should be initiated and monitored by a hepatologist, gastroenterologist, or metabolic disease specialist.
- Discontinue Cholbam if liver function does not improve within 3 months of starting treatment or complete biliary obstruction develops.
- Discontinue treatment with Cholbam at any time if there are persistent clinical or laboratory indicators of worsening liver function or cholestasis.
- The safety and effectiveness of Cholbam on extrahepatic manifestations of bile acid synthesis disorders due to SEDs or PDs including Zellweger spectrum disorders have not been established.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Bile acid synthesis disorders due to SED, PD including Zellweger spectrum disorders	10 to 15 mg/kg/day administered PO in one or two divided doses For concomitant familial hypertriglyceridemia: 11 to 17 mg/kg/day PO in one or two divided doses	17 mg/kg/day

VI. Product Availability

Capsules: 50 mg, 250 mg

VII. References

1. Cholbam Prescribing Information. San Diego, CA: Retrophin, Inc.; October 2020. Available at: www.cholbam.com. Accessed July 21, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	08.14.18	11.18
4Q 2019 annual review: no significant changes; added Medicaid line of business with 6/12 month approval durations; references reviewed and updated.	07.30.19	11.19
4Q 2020 annual review: updated criteria to require diagnosis confirmation, allow metabolic disease specialist, and require evidence of improvement in LFTs for continued therapy; shortened initial approval duration to 3 months from 6 months for Medicaid/Length of Benefit for commercial per PI stating that therapy should be discontinued if insufficient response or complete biliary obstruction occurs at 3 months; references reviewed and updated.	06.26.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	07.02.21	11.21
4Q 2022 annual review: no significant changes; references reviewed and updated.	07.21.22	11.22

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.