Pharmacy Medical Necessity Guidelines: Bylvay™ (odevixibat)

Effective: January 1, 2025

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS

Bylvay (odevixibat) is an ileal bile acid transporter (IBAT) inhibitor indicated for the treatment of:

Alagille Syndrome

- Cholestatic pruritus in patients 12 months of age and older with Alagille Syndrome

Progressive Familial Intrahepatic Cholestasis

- Pruritus in patients 3 months of age and older with progressive familial intrahepatic cholestasis.

  Bylvay (odevixibat) may not be effective in PFIC type 2 patients with ABCB11 variants resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3).

COVERAGE GUIDELINES

The plan may authorize coverage of Bylvay (odevixibat) for Members when all of the following criteria are met:

Alagille Syndrome

Initial Authorization Criteria

1. Documented diagnosis of Alagille Syndrome confirmed by genetic testing demonstrating the presence of a jagged canonical notch ligand 1 (JAG1) or notch receptor 2 (NOTCH2) mutation

AND

2. Documentation of cholestasis as defined by at least **one (1)** of the following:
   a. Total serum bile acid greater than 3 times the upper limit of normal for age
   b. Conjugated bilirubin greater than 1 mg/dL
   c. Fat soluble vitamin deficiency that is otherwise unexplainable
   d. Gamma Glutamyl Transferase (GCT) greater than 3 times the upper limit for age
   e. Intractable pruritus explainable only by liver disease

AND

3. Prescribed by or in consultation with a hepatologist, gastroenterologist, or a provider who specializes in Alagille Syndrome (ALGS)

AND

4. Patient is 12 months of age or older

AND

5. Documentation of moderate to severe pruritus

AND

6. Documentation of **one (1)** of the following:
   a. Inadequate response to at least two (2) other medications to treat pruritus (e.g., ursodeoxycholic acid, antihistamines, rifampin, naltrexone, bile acid sequestrants)
   b. Clinical inappropriateness for use of other medications to treat pruritus

Reauthorization Criteria

1. Documented diagnosis of Alagille Syndrome confirmed by genetic testing demonstrating the presence of a jagged canonical notch ligand (JAG1) or notch receptor 2 (NOTCH2) mutation

AND

2. Prescribed by or in consultation with a hepatologist, gastroenterologist, or a provider who specializes in Alagille Syndrome (ALGS)

AND

3. Patient is 12 months of age or older

AND

4. Documentation of a positive clinical response as evidenced by **one (1)** of the following:
    a. Improvement in severity of pruritus
    b. Reduction in serum bile acid from baseline

AND

5. Documentation the patient has not had a liver transplantation

Progressive Familial Intrahepatic Cholestasis

Initial Authorization Criteria

1. Documented diagnosis of progressive familial intrahepatic cholestasis

AND

2. Documentation of molecular genetic testing confirming both of the following:
    a. Diagnosis of progressive familial intrahepatic cholestasis
    b. No indication of progressive familial intrahepatic cholestasis type 2 with ABCB11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3)

AND

3. Prescribed by or in consultation with a hepatologist, gastroenterologist, or a provider who specializes in progressive familial intrahepatic cholestasis

AND

4. The patient is 3 months of age or older

AND

5. Documentation of moderate to severe pruritus

AND

6. Documentation of trial and failure with at least **one (1)** systemic medication considered standard of care for progressive familial intrahepatic cholestasis, unless contraindicated (e.g., antihistamines, cholestyramine, rifampicin, ursodiol)

AND

7. Documentation the patient has not had a liver transplant

Reauthorization Criteria

1. Documented diagnosis of progressive familial intrahepatic cholestasis

AND

2. Documentation of molecular genetic testing confirming both of the following:
    a. Diagnosis of progressive familial intrahepatic cholestasis
    b. No indication of progressive familial intrahepatic cholestasis type 2 with ABCB11 variants encoding for nonfunction or absence of bile salt export pump protein (BSEP-3)

AND

3. Prescribed by or in consultation with a hepatologist, gastroenterologist, or a provider who specializes in progressive familial intrahepatic cholestasis

AND

4. The patient is 3 months of age or older

AND

5. Documentation of a positive clinical response as evidenced by **one (1)** of the following:
    a. Improvement in severity of pruritus
    b. Reduction in serum bile acid from baseline

AND

6. Documentation the Member has not had a liver transplantation

LIMITATIONS

- Initial coverage of Bylvay will be authorized for 6 months. Reauthorization of Bylvay will be provided in 12-month intervals.
- Members new to the plan stable on Bylvay should be reviewed against Reauthorization Criteria.

CODES

None

REFERENCES

1. Amirneni S, Haep N, Gad MA, Soto-Gutierrez A, Squires JE, Florentino RM. Molecular overview of progressive familial intrahepatic cholestasis. *World J Gastroenterol*. 2020; 26(47):7470-7484.
2. Ayoub MB, et al. Alagille syndrome: diagnostic challenges and advances in management. Diagnostics (Basel). 2020;10(11):907.
3. Baker A, Kerkar N, Todorova L, Kamath BM, Houwen RH. Systematic review of progressive familial intrahepatic cholestasis. *Clin Res Hepatol Gastroenterol.* 2019;43(1):20-36.
4. Bylvay (odevixibat) [prescribing information]. Boston, MA: Albireo Pharma, Inc.; July 2021.
5. Mitchell E, Gilbert M, Loomes KM. Alagille syndrome. Clin Liver Dis. 2018;22(4):625-641
6. Schwartz R, Rehder K, Parsons DJ, Morrell DS. Intense pruritus and failure to thrive in Alagille syndrome. J Am Acad Dermatol. 2008;58(2 Suppl):S9-11.
7. Srivastava A. Progressive familial intrahepatic cholestasis. *J Clin Exp Hepatol.* 2014;4(1):25-36.
8. Thompson RJ, Baumann U, Czubkowski P, et al. Efficacy and safety of odevixibat, an ileal bile acid transporter inhibitor, in children with progressive familial intrahepatic cholestasis types 1 and 2: results from PEDFIC 1, a randomized, double-blind, placebo-controlled phase 3 trial. Abstract presented at: American Association of Liver Diseases; November 15, 2020; Accessed August 16, 2021.
9. Thompson R, Artan R, Baumann U, et al. Odevixibat effects on cholestasis-related parameters: analysis of pooled data from the PEDFIC 1 and PEDFIC 2 studies in children with progressive familial intrahepatic cholestasis. Poster presented at the International Liver Congress; June 23-26, 2021; virtual.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy & Therapeutics Committee.

- June 13, 2023: No changes
- August 8, 2023: Added coverage criteria for supplemental indication of Alagille Syndrome (effective September 1, 2023)
- February 13, 2024: For Alagille syndrome, added Documentation of one (1) of the following: Inadequate response to at least two (2) other medications to treat pruritus (e.g., ursodeoxycholic acid, antihistamines, rifampin, naltrexone, bile acid sequestrants) or Clinical inappropriateness for use of other medications to treat pruritus. For Alagille syndrome, updated diagnosis requirements to include genetic testing confirming the diagnosis. Minor wording changes to the genetic testing for progressive familial intrahepatic cholestasis. For both indications, added the requirement of moderate to severe pruritus (effective May 1, 2024).
- October 8, 2024: Retire Medical Necessity Guideline. Coverage is moved to non-formulary status effective 1/1/25 (eff 12/31/2024)
- November 12, 2024: Un-retire Medical Necessity Guideline based on 2025 coverage (eff 1/1/25).

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services