



PHARMACY COVERAGE GUIDELINES  
SECTION: DRUGS

ORIGINAL EFFECTIVE DATE: 9/15/16  
LAST REVIEW DATE: 9/20/18  
LAST CRITERIA REVISION DATE: 9/20/18  
ARCHIVE DATE:

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## OCALIVA™ (obeticholic acid) oral tablet

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Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at [www.azblue.com/pharmacy](http://www.azblue.com/pharmacy).

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to [Pharmacyprecert@azblue.com](mailto:Pharmacyprecert@azblue.com). **Incomplete forms or forms without the chart notes will be returned.**

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## OCALIVA™ (obeticholic acid) oral tablet (cont.)

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### Criteria:

- **Criteria for initial therapy:** Ocaliva (obeticholic acid) is considered *medically necessary* and will be approved when **ALL** of the following criteria are met:
1. Requesting provider is a Hepatologist who specializes in Primary Biliary Cholangitis (PBC) or Gastroenterologist in consultation with a Hepatologist who specializes in PBC
  2. Individual is 18 years of age or older
  3. A confirmed diagnosis of primary biliary cholangitis (PBC) confirmed by **TWO** of the following:
    - Positive antimitochondrial antibodies (AMA)
    - Presence of cholestasis with a history of increased ALP levels of at least 1.5x ULN for more than 6 months
    - Liver biopsy consistent with PBC that shows chronic non-suppurative cholangitis of the small and medium size bile ducts. A liver biopsy is typically not required.
  4. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
    - Child-Pugh classification
    - Comprehensive metabolic panel
  5. Individual has failure, contraindication or intolerance to appropriate dose of Ursodeoxycholic acid (UDCA) after 1 year use
    - Failure of UDCA is defined as an ALP that is 1.67x upper limit of normal (UNL) and/or total bilirubin is > 1x UNL but < 2x UNL
  6. There are **NO** contraindications
    - Contraindications include:
      - Complete biliary obstruction

**Initial approval duration:** 3 months

- **Criteria for continuation of coverage (renewal request):** Ocaliva (obeticholic acid) is considered *medically necessary* and will be approved with documentation of **ALL** of the following:
1. Continues to be seen by Hepatologist or Gastroenterologist
  2. Individual's condition has responded while on therapy
    - Response is defined as:
      - Achieved and maintains ALP < 1.67x UNL or ALP decreased by at least 15% over baseline
      - Achieved and maintains total bilirubin is ≤ UNL
  3. Individual has been adherent with the medication

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## **OCALIVA™ (obeticholic acid) oral tablet (cont.)**

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4. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use, such as:
  - Complete biliary obstruction
  - Severe, persistent, intolerable pruritus despite management strategies
  - Significant liver adverse reactions
5. There are no significant interacting drugs

**Renewal duration:** 12 months

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### **Description:**

Ocaliva (obeticholic acid) 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.** This indication was approved based on a reduction in alkaline phosphatase (ALP). An improvement in survival or disease-related symptoms has not been established. Treatment with Ocaliva (obeticholic acid) in patients with moderate and severe hepatic impairment should be initiated and monitored by a healthcare provider with experience managing PBC.

PBC is an autoimmune disease that is characterized by progressive destruction of the small and medium sized intrahepatic biliary ducts. With ongoing inflammation and scarring of the bile ducts, bile cannot be carried from the liver to the intestine. There is progressive impairment of bile flow, increased hepatocellular bile concentration, and cellular injury. As a result, bile builds up in the liver causing cholestasis and jaundice (obstructive jaundice). Fibrosis and cirrhosis occur as the disease advances over a few years or in some a few decades. Most patients are asymptomatic at the time of their diagnosis, and it is often diagnosed based on elevated alkaline phosphatase (ALP). PBC was initially known as primary biliary cirrhosis but the name was changed due to cirrhosis being an advanced feature of the disease.

PBC is a relatively rare disease affecting 1 in 4,000 individuals and it is seen more commonly in females in a ratio of 9:1 with a peak incidence in the fifth decade of life. The diagnosis of PBC can be made by two of the following 3 American Association for the Study of Liver Diseases (AASLD) 2009 criteria: positive antimitochondrial antibodies (AMA), presence of cholestasis with a history of increased ALP levels for more than 6 months, or liver biopsy consistent with PBC that shows chronic suppurative cholangitis of the small and medium size bile ducts. A liver biopsy is typically not required.

Bile acids are ligands of the nuclear receptor, farnesoid X receptor (FXR). The FXR is a member of the nuclear receptor superfamily that is highly expressed in liver, intestine, kidney, and adrenal glands. The most potent natural FXR ligand is chenodeoxycholic acid (CDCA, chenodiol), but other bile acids, cholic, lithocholic, and deoxycholic also activate FXR.

Obeticholic acid is an agonist for FXR. FXR is a key regulator of bile acid, inflammatory, fibrotic, and metabolic pathways. Recent studies show that FXR is the primary sensor of bile acids and is involved in every aspect of bile acid metabolism, including bile acid synthesis, transport, detoxification, and excretion in the liver and intestine. FXR activation decreases the intracellular hepatocyte concentrations of bile acids by suppressing *de novo*

## **OICALIVA™ (obeticholic acid) oral tablet (cont.)**

synthesis from cholesterol as well as by increased transport of bile acids out of the hepatocytes. These mechanisms limit the overall size of the circulating bile acid pool while promoting choleresis, thus reducing hepatic exposure to bile acids.

In clinical trials, administration of Ocaliva (obeticholic acid) 10 mg once daily was also associated with an increase from baseline in concentrations of fibroblast growth factor (FGF)-19, an FXR-inducible enterokine involved in bile acid homeostasis. Concentrations of cholic acid and CDCA were reduced from baseline also. Fibroblast growth factors (FGFs) represent a large gene family of proteins involved in cell growth and differentiation, embryonic development, angiogenesis, and wound healing. FGF-19 is involved in controlling the enterohepatic bile acid/cholesterol system. FGF-19 also exerts important regulatory effects on glucose, protein, and lipid metabolism. The clinical relevance of these findings is unknown.

Obeticholic acid is a modified bile acid with structural similarity to endogenous CDCA. Obeticholic acid is conjugated with glycine or taurine in the liver and secreted into bile. These glycine and taurine conjugates of obeticholic acid are pharmacologically active and are absorbed in the small intestine leading to enterohepatic recirculation. The conjugates can be deconjugated in the ileum and colon by intestinal microbiota, leading to the conversion to obeticholic acid that can be reabsorbed or excreted in feces. A third obeticholic acid metabolite, 3-glucuronide, is formed but is considered to have minimal pharmacologic activity.

### **Definitions:**

#### **Diagnostic criteria for PBC: (from American Association for the Study of Liver Disease 2009)**

Two of the following three criteria:

- Positive antimitochondrial antibodies (AMA)
- Presence of cholestasis with a history of increased ALP levels of at least 1.5x ULN for more than 6 months
- Liver biopsy consistent with PBC that shows chronic non-suppurative cholangitis of the small and medium size bile ducts. A liver biopsy is typically not required.

### **Child-Pugh Classification:**

| <b>Child-Pugh Classification of severity of liver disease</b> |                |                    |                 |
|---|----------------|--------------------|-----------------|
| Child-Pugh Classification                                     | Points         |                    |                 |
| A: Well compensated   | 5-6            |                    |                 |
| B: Significant functional compromise                          | 7-9            |                    |                 |
| C: Decompensated  | 10-15          |                    |                 |
| Parameter/Factor  | 1 point each   | 2 points each      | 3 points each   |
| Total Bilirubin:<br>(mg/dL) or (µmol/L)                       | < 2 (or < 34)  | 2-3 (or 34-50)     | > 3 or (> 50)   |
| Albumin<br>(g/dL) or (g/L)                                    | >3.5 (or > 35) | 2.8-3.5 (or 28-35) | < 2.8 (or < 28) |
| Prothrombin time  |                |                    |                 |
| Seconds over control  | 1-3            | 4-6                | > 6             |

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|                | INR | < 1.7  | 1.71-2.3                                  | > 2.3                     |
|----------------|-----|--------|---|---------------------------|
| Ascites        |     | Absent | Slight/Mild                               | Moderate to severe        |
| Encephalopathy |     | None   | Grade 1-2 (or suppressed with medication) | Grade 3-4 (or refractory) |

**Decompensation events:**

- Appearance of ascites
- Gastroesophageal variceal bleeding
- New or worsening jaundice
- Encephalopathy
- Spontaneous bacterial peritonitis

The appearance of ascites, variceal bleeding, encephalopathy, or jaundice, the major clinical manifestations of liver cirrhosis, marks the transition from the *compensated* phase into the *decompensated* phase of cirrhosis

**Encephalopathy Grades:**

|         |   |
|---------|---|
| Grade 0 | <ul style="list-style-type: none"> <li>• Minimal hepatic encephalopathy (also known as covert hepatic encephalopathy and previously known as subclinical hepatic encephalopathy)</li> <li>• Lack of detectable changes in personality or behavior</li> <li>• Minimal changes in memory, concentration, intellectual function, and coordination</li> <li>• Asterixis is absent</li> </ul>        |
| Grade 1 | <ul style="list-style-type: none"> <li>• Trivial lack of awareness</li> <li>• Shortened attention span</li> <li>• Impaired performance with addition or subtraction</li> <li>• Hypersomnia, insomnia, or inversion of sleep pattern</li> <li>• Euphoria or anxiety, depression, or irritability</li> <li>• Mild confusion</li> <li>• Slowing of ability to perform mental tasks</li> </ul>      |
| Grade 2 | <ul style="list-style-type: none"> <li>• Lethargy or apathy</li> <li>• Minimal disorientation for time and place</li> <li>• Inappropriate behavior</li> <li>• Impaired performance with subtraction</li> <li>• Slurred speech</li> <li>• Obvious asterixis</li> <li>• Drowsiness</li> <li>• Gross deficits in ability to perform mental tasks</li> <li>• Obvious personality changes</li> </ul> |

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|         |  |
|---------|--|
| Grade 3 | <ul style="list-style-type: none"> <li>• Somnolence to semi-stupor, but responsive to verbal stimuli</li> <li>• Marked confusion</li> <li>• Gross disorientation</li> <li>• Unable to perform mental tasks</li> <li>• Amnesia</li> <li>• Occasional fits of rage</li> <li>• Incomprehensible speech</li> </ul> |
| Grade 4 | <ul style="list-style-type: none"> <li>• Coma (unresponsive to verbal or noxious stimuli)</li> <li>• Coma with or without response to painful stimuli</li> </ul>   |

**Resources:**

Ocaliva (obeticholic acid). Package Insert. Revised by manufacturer 02/2018. Accessed 07-19-2018.

Ocaliva (obeticholic acid). Package Insert. Revised by manufacturer 05/2016. Accessed 08-01-2016.

Poupon R. Primary biliary cirrhosis: A 2010 update. J Hepatology 2010; 52: 745-758

Lindor KD, Gershwin ME, Poupon R, et al.: American Association for the Study of Liver Diseases (AASLD) Practice Guidelines: Primary biliary cirrhosis. Hepatology 2009; 50(1): 291-308

UpToDate: Overview of the treatment of primary biliary cholangitis (primary biliary cirrhosis). Current through Jul 2017. [https://www.uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-primary-biliary-cholangitis-primary-biliary-cirrhosis?source=search\\_result&search=primary%20biliary%20cirrhosis&selectedTitle=1~145#H22](https://www.uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-primary-biliary-cholangitis-primary-biliary-cirrhosis?source=search_result&search=primary%20biliary%20cirrhosis&selectedTitle=1~145#H22)

UpToDate: Clinical manifestations, diagnosis, and prognosis of primary biliary cholangitis (primary biliary cirrhosis). Current through Jul 2017. [https://www.uptodate-com.mwu.idm.oclc.org/contents/clinical-manifestations-diagnosis-and-prognosis-of-primary-biliary-cholangitis-primary-biliary-cirrhosis?source=see\\_link#H58140621](https://www.uptodate-com.mwu.idm.oclc.org/contents/clinical-manifestations-diagnosis-and-prognosis-of-primary-biliary-cholangitis-primary-biliary-cirrhosis?source=see_link#H58140621)



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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com. Call 866-325-1794 to check the status of a request. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

# Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED:** Office notes, labs, and medical testing relevant to the request that show medical justification are required.

| Member Information          |                |         |             |
|-----------------------------|----------------|---------|-------------|
| Member Name (first & last): | Date of Birth: | Gender: | BCBSAZ ID#: |
| Address:                    | City:          | State:  | Zip Code:   |

| Prescribing Provider Information |               |             |           |
|----------------------------------|---------------|-------------|-----------|
| Provider Name (first & last):    | Specialty:    | NPI#:       | DEA#:     |
| Office Address:                  | City:         | State:      | Zip Code: |
| Office Contact:                  | Office Phone: | Office Fax: |           |

| Dispensing Pharmacy Information |                 |               |
|---------------------------------|-----------------|---------------|
| Pharmacy Name:                  | Pharmacy Phone: | Pharmacy Fax: |

| Requested Medication Information |           |              |                          |
|----------------------------------|-----------|--------------|--------------------------|
| Medication Name:                 | Strength: | Dosage Form: |                          |
| Directions for Use:              | Quantity: | Refills:     | Duration of Therapy/Use: |

Check if requesting **brand** only     Check if requesting **generic**

Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

| Turn-Around Time For Review   |   |
|---|---|
| <input type="checkbox"/> Standard <input type="checkbox"/> Urgent. Sign here: _____ | <input type="checkbox"/> Exigent (requires prescriber to include a written statement) |

### Clinical Information

1. **What is the diagnosis? Please specify below.**  
 ICD-10 Code: \_\_\_\_\_      Diagnosis Description: \_\_\_\_\_

2.  Yes     No      **Was this medication started on a recent hospital discharge or emergency room visit?**

3.  Yes     No      **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**  
 Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

| Medication Name, Strength, Frequency | Dates started and stopped or Approximate Duration | Describe response, reason for failure, or allergy |
|--------------------------------------|---|---|
|                                      |   |   |
|                                      |   |   |
|                                      |   |   |
|                                      |   |   |
|                                      |   |   |
|                                      |   |   |

5. **Are there any supporting labs or test results? Please specify below.**

| Date | Test | Value |
|------|------|-------|
|      |      |       |
|      |      |       |
|      |      |       |
|      |      |       |
|      |      |       |
|      |      |       |

# Pharmacy Prior Authorization Request Form

**6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.**  
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**Signature affirms that information given on this form is true and accurate and reflects office notes**

|                                   |       |
|-----------------------------------|-------|
| Prescribing Provider's Signature: | Date: |
|-----------------------------------|-------|

**Please note:** Some medications may require completion of a drug-specific request form.

**Incomplete forms or forms without the chart notes will be returned.**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.