MEDICAL MUTUAL®

Drug Policy

Policy: SD	Bylvay (odevixibat)	Annual Review Date: 08/22/2024 Last Revised Date: 08/22/2024

OVERVIEW

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

- Pruritus in patients ≥ 3 months of age with progressive familial intrahepatic cholestasis (PFIC).[1]
- Cholestatic pruritus in patients ≥ 12 months of age with Alagille syndrome (ALGS).[1]

Pruritus is a common symptom in patients with PFIC and ALGS; the pathophysiology of pruritus in patients with PFIC is not completely understood. Although the complete mechanism by which Bylvay improves pruritus in both PFIC and ALGS patients is unknown, it may involve inhibition of the IBAT, which results in decreased reuptake of bile salts, as observed by a decrease in serum bile acids.[1]

POLICY STATEMENT

This policy involves the use of Bylvay. Prior authorization is recommended for pharmacy benefit coverage of Bylvay. Approval is recommended for those who meet the conditions of coverage in the **Criteria and Initial/Extended Approval** for the diagnosis provided. **Conditions Not Recommended for Approval** are listed following the recommended authorization criteria. Requests for uses not listed in this policy will be reviewed for evidence of efficacy and for medical necessity on a case-by-case basis.

Because of the specialized skills required for evaluation and diagnosis of patients treated with Bylvay as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Bylvay be prescribed by or in consultation with a physician who specializes in the condition being treated. All approvals for initial therapy are provided for the initial approval duration noted below; if reauthorization is allowed, a response to therapy is required for continuation of therapy unless otherwise noted below.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Bylvay is recommended in those who meet the following criteria:

FDA-Approved Indication

1. **Progressive Familial Intrahepatic Cholestasis**. Approve for the duration noted if the patient meets one of the following (A or B):
   - **A)** Initial Therapy: Approve for 6 months if the patient meets all of the following (i, ii, iii, iv, v, vi and vii):
     - **i.** The patient is ≥ 3 months of age; AND

ii. The patient has moderate-to-severe pruritis, according to the prescriber; AND

iii. The diagnosis of progressive familial intrahepatic cholestasis was confirmed by genetic testing demonstrating a gene mutation affiliated with progressive familial intrahepatic cholestasis; AND
Note: Gene mutations affiliated with progressive familial intrahepatic cholestasis include the *ATP8B1* gene, *ABCB11* gene, *ABCB4* gene, *TJP2* gene, *NR1H4* gene, and *MYO5B* gene.

iv. The patient does not have any of the following (a, b, or c):
- **a.** Cirrhosis; OR
- **b.** Portal hypertension; OR
- **c.** History of a hepatic decompensation event; AND
  Note: Examples of a hepatic decompensation event include variceal hemorrhage, ascites, and hepatic encephalopathy.

v. The patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory; AND

vi. The patient has tried at least two systemic medications for progressive familial intrahepatic cholestasis, unless contraindicated; AND
Note: Systemic medications for progressive familial intrahepatic cholestasis include cholestyramine, naltrexone, rifampicin, sertraline, and ursodeoxycholic acid (ursodiol).

vii. The medication is prescribed by or in consultation with a hepatologist, gastroenterologist, or a physician who specializes in progressive familial intrahepatic cholestasis.

B) Patient is Currently Receiving Bylvay. Approve for 1 year if the patient meets all of the following conditions(i, ii, and iii):

i. Patient does not have any of the following (a, b, or c):
- **a.** Cirrhosis; OR
- **b.** Portal hypertension; OR
- **c.** History of a hepatic decompensation event; AND
  Note: Examples of a hepatic decompensation event include variceal hemorrhage, ascites, and hepatic encephalopathy.

ii. Patient had response to therapy as determined by the prescriber; AND
Note: Examples of response to therapy include decrease in serum bile acids and decrease in pruritis.

iii. The medication is prescribed by or in consultation with a hepatologist, gastroenterologist, or a physician who specializes in progressive familial intrahepatic cholestasis.

2. Alagille Syndrome. Approve for the duration noted if the patient meets one of the following (A or B):

A) Initial Therapy. Approve for 6 months if the patient meets all of the following (i, ii, iii, iv, v, vi and vii):

i. Patient is ≥ 12 months of age; AND

ii. Patient has moderate-to-severe pruritus, according to the prescriber; AND

iii. Diagnosis of Alagille syndrome was confirmed by genetic testing demonstrating a *JAG1* or *NOTCH2* deletion or mutation; AND

iv. Patient has a serum bile acid concentration above the upper limit of the normal reference range for the reporting laboratory; AND

v. Patient has tried at least two systemic medications for Alagille syndrome, unless contraindicated; AND

Note: Systemic medications for Alagille syndrome include cholestyramine, naltrexone, rifampicin, sertraline, and ursodeoxycholic acid (ursodiol).

vi. Patient does not have any of the following (a, b, or c):
- **a)** Cirrhosis; OR
- **b)** Portal hypertension; OR
- **c)** History of a hepatic decompensation event; AND
  Note: Examples of a hepatic decompensation event include variceal hemorrhage, ascites, and hepatic encephalopathy.

vii. The medication is prescribed by or in consultation with a hepatologist, gastroenterologist, or a physician who specializes in Alagille syndrome.

B) Patient is Currently Receiving Bylvay. Approve for 1 year if the patient meets all of the following (i, ii, and iii):

i. Patient does not have any of the following (a, b, or c):
- **a)** Cirrhosis; OR
- **b)** Portal hypertension; OR
- **c)** History of a hepatic decompensation event; AND
  Note: Examples of a hepatic decompensation event include variceal hemorrhage, ascites, and hepatic encephalopathy.

ii. Patient had response to therapy, as determined by the prescriber; AND
Note: Examples of response to therapy include decrease in serum bile acids and decrease in pruritus.

iii. The medication is prescribed by or in consultation with a hepatologist, gastroenterologist, or a physician who specializes in Alagille syndrome.

Initial Approval/ Extended Approval.
A) *Initial Approval:* 6 months
B) *Extended Approval:* 1 year

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Bylvay has not been shown to be effective, or there are limited or preliminary data or potential safety concerns that are not supportive of general approval for the following conditions. (Note: This is not an exhaustive list of Conditions Not Recommended for Approval).

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

Documentation Requirements:

The Company reserves the right to request additional documentation as part of its coverage determination process. The Company may deny reimbursement when it has determined that the drug provided or services performed were not

medically necessary, investigational or experimental, not within the scope of benefits afforded to the member and/or a pattern of billing or other practice has been found to be either inappropriate or excessive. Additional documentation supporting medical necessity for the services provided must be made available upon request to the Company. Documentation requested may include patient records, test results and/or credentials of the provider ordering or performing a service. The Company also reserves the right to modify, revise, change, apply and interpret this policy at its sole discretion, and the exercise of this discretion shall be final and binding.

REFERENCES

1. Bylvay™ capsules and oral pellets [prescribing information]. Boston, MA: Albireo Pharma; February 2024.
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3. Amirneni S, Haep N, Gad MA, et al. Molecular overview of progressive familial intrahepatic cholestasis. *World J Gastroenterol*. 2020 Dec 21;26(47):7470-7484.
4. Gunaydin M, Bozkurter Cil AT. Progressive familial intrahepatic cholestasis: diagnosis, management, and treatment. *Hepat Med*. 2018 Sep 10;10:95-104.
5. van der Woerd WL, Houwen RH, van de Graaf SF. Current and future therapies for inherited cholestatic liver diseases. *World J Gastroenterol*. 2017 Feb 7;23(5):763-775.
6. Gunaydin M, Bozkurter C. Progressive familial intrahepatic cholestasis: diagnosis, management, and treatment. *Hepat Med*. 2018 Sep 10;10:95-104.
7. European Association for the Study of the Liver. EASL Clinical Practice Guidelines: management of cholestatic liver diseases. *J Hepatol*. 2009 Aug;51(2):237-67.
8. Alagille syndrome. National Organization for Rare Disorders. Updated 2024. Available at: https://rarediseases.org/rare-diseases/alagille-syndrome/. Accessed on July 16, 2024.
9. Diaz-Frias J, Kondamudi NP. Alagille Syndrome. [Updated 2022 Aug 14]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK507827/. Accessed on July 16, 2024.