

## Clinical Policy: Hepatic and Biliary Agents

Reference Number: PHW.PDL.198

Effective Date: 01/01/2020

Last Review Date: 11/2025

### 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 PA Health & Wellness® that Hepatic and Biliary Agents are **medically necessary** when the following criteria are met:

#### I. Requirements for Prior Authorization of Hepatic and Biliary Agents

##### A. Prescriptions That Require Prior Authorization

Prescriptions for Hepatic and Biliary Agents that meet any of the following conditions must be prior authorized:

1. A non-preferred Hepatic and Biliary Agent.
2. A Hepatic and Biliary Agent with a prescribed quantity that exceeds the quantity limit.
3. A prescription for cholic acid.
4. A prescription for a peroxisome proliferator-activated receptor (PPAR) agonist (e.g., elafibranor) Hepatic and Biliary Agent.

##### B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Hepatic and Biliary Agent, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. Is prescribed the Hepatic and Biliary Agent for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**
2. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
3. Does not have a contraindication to the requested drug; **AND**
4. For cholic acid, **both** of the following:

- a. Is prescribed cholic acid by or in consultation with a hepatologist or pediatric gastroenterologist,
  - b. Has documentation of a medical history and lab test results that support the member's diagnosis;
5. For a PPAR agonist Hepatic and Biliary Agent, **both** of the following:
- a. Is prescribed the requested drug by or in consultation with a hepatologist or gastroenterologist
  - b. Has documentation of a medical history and lab test results that support the member's diagnosis;
6. For all other non-preferred Hepatic and Biliary Agents, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hepatic and Biliary Agents approved or medically accepted for the member's diagnosis; **AND**
7. If a prescription for a Hepatic and Biliary Agents is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

**FOR RENEWALS OF PRESCRIPTIONS FOR HEPATIC AND BILIARY AGENTS:**  
The determination of medical necessity of requests for renewal of a prior authorization for a Hepatic and Biliary Agent that was previously approved will take into account whether the member:

1. Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**
2. Does not have a contraindication to the requested drug; **AND**
3. For cholic acid, **all** of the following:
  - a. Is prescribed cholic acid by or in consultation with a hepatologist or pediatric gastroenterologist,
  - b. Has documented improvement in liver function within the first 3 months of treatment,
  - c. Does not have complete biliary obstruction, persistent clinical or laboratory indicators of worsening liver function, or cholestasis;

**AND**

4. For a PPAR agonist Hepatic and Biliary Agent, **both** of the following:
  - a. Is prescribed the requested drug by or in consultation with a hepatologist or gastroenterologist
  - b. Has documentation of a positive response to the requested drug as evidenced by liver function tests;
5. For all other non-preferred Hepatic and Biliary Agents, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Hepatic and Biliary Agents approved or medically accepted for the member's diagnosis; **AND**
6. If a prescription for a Hepatic and Biliary Agent is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

**C. Clinical Review Process**

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B above, to assess the medical necessity of the request for a prescription for a Hepatic and Biliary Agents. If the guidelines in Section B are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the recipient.

**D. Approval Duration:**

- **New request: 6 months**
- **Renewal request: 12 months**

**E. References:**

1. Cholbam [package insert]. San Diego, CA: Manchester Pharmaceuticals, Inc.; October 2020.
2. Iqirvo [package insert]. Cambridge, MA: Ipsen Biopharmaceuticals, Inc. June 2024.
3. Livdelzi [package insert]. Foster City, CA: Gilead Sciences, Inc. August 2024.
4. Erlichman J, Loomes KM. Causes of cholestasis in neonates and young children. In: UpToDate [internet database]. Abrams SA, Rand EB, Hoppin AG, eds. Waltham, MA: UpToDate Inc. Updated January 19, 2022. Accessed April 21, 2022.

5. Wanders RJA. Peroxisomal disorders. In: UpToDate [internet database]. Patterson MC, Firth HV, Armsby C, eds. Waltham, MA: UpToDate Inc. Updated March 3, 2020. Accessed April 21, 2022.
6. Poupon R. Overview of the management of primary biliary cholangitis. In: UpToDate [internet database]. Lindor KD, Robson KM, eds. Waltham, MA: UpToDate Inc. Updated July 26, 2024. Accessed August 14, 2024.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2023: policy revised according to DHS revisions effective 01/09/2023.	10/2022
Q1 2024 annual review: no changes.	11/2023
Q1 2025: policy revised according to DHS revisions effective 01/06/2025.	11/2024
Q1 2026: policy revised according to DHS revisions effective 01/05/2026.	11/2025