Clinical Policy: Cholic Acid (Cholbam)

Reference Number: CP.PHAR.390
Effective Date: 12.01.18
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, 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.

It is the policy of health plans affiliated with Centene Corporation® 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 (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Bile Acid Synthesis Disorders or Peroxisomal Disorders (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
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:
Medicaid/HIM/ICHRA – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

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 policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

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.
- Discontinue Cholbam if liver function does not improve within 3 months of starting treatment or complete biliary obstruction develops.
- 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.; January 2026. Available at: https://cholbam.com/wp-content/uploads/2023/04/CHOLBAM-Prescribing-Information-2023-04.pdf. Accessed July 10, 2026.
2. Braverman NE, Raymond GV, Rizzo WB, et al. Peroxisome biogenesis disorders in the Zellweger spectrum: An overview of current diagnosis, clinical manifestations, and treatment guidelines. Mol Genet Metab. 2016 Mar;117(3):313-21. doi: 10.1016/j.ymgme.2015.12.009. Epub 2015 Dec 23. PMID: 26750748; PMCID: PMC5214431.
3. Bile acid synthesis disorders. National Organization for Rare Disease. Updated October 2, 2024. Available at: https://rarediseases.org/rare-diseases/bile-acid-synthesis-disorders/. Accessed July 30, 2026.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	07.21.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	06.29.23	11.23
4Q 2024 annual review: no significant changes; removed supplemental information in Appendix D; references reviewed and updated.	07.15.24	11.24
4Q 2025 annual review: no significant changes; references reviewed and updated.	07.10.25	11.25
4Q 2026 annual review: no significant changes; added ICHRA line of business; references reviewed and updated.	07.10.26	11.26

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. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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