Clinical Policy: Colesevelam (Welchol)

Reference Number: CP.PMN.250
Effective Date: 12.01.20
Last Review Date: 11.26
Line of Business: HIM/ICHRA, Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Colesevelam (Welchol®) is a bile acid sequestrant.

FDA Approved Indication(s)

Welchol is indicated as an adjunct to diet and exercise for:

Primary Hyperlipidemia

- To reduce elevated low density lipoprotein cholesterol (LDL-C) in adults with primary hyperlipidemia.
- To reduce LDL-C levels in boys and postmenarchal girls, 10 to 17 years of age, with heterozygous familial hypercholesterolemia (HeFH) if unable to reach LDL-C target levels despite an adequate trial of dietary therapy and lifestyle modification.

Type 2 Diabetes Mellitus

- To improve glycemic control in adults with type 2 diabetes mellitus.

Limitation(s) of use:

- Welchol should not be used for the treatment of type 1 diabetes or for treating diabetic ketoacidosis.
- Welchol has not been studied in Fredrickson Type I, III, IV, and V dyslipidemias.

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 Welchol packet for suspension is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Primary Hyperlipidemia (must meet all)**:**

1. Request is for Welchol packet for suspension;
2. Prescribed for lipid lowering;
3. Age ≥ 10 years;
4. Documentation supports inability to swallow pills or clinically significant adverse effects to Welchol tablets;
5. Failure of colestipol granules and cholestyramine powder for suspension at up to maximally indicated doses, each used for ≥ 3 months, unless contraindicated or clinically significant adverse effects are experienced;†

†For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395

6. Failure of ≥ 3 consecutive months of adherent use of a statin therapy, unless contraindicated or clinically significant adverse effect are experienced;†
   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
7. At the time of request, current (within the last 3 months) serum triglyceride concentrations do not exceed 500 mg/dL;
8. If request is for brand Welchol packet for suspension, member must use generic colesevelam packet for suspension, unless contraindicated or clinically significant adverse effects are experienced;
9. Dose does not exceed oral suspension packet of 3.75 grams (1 packet) per day.

Approval duration: 12 months

B. Type 2 Diabetes Mellitus (must meet all)**:**

1. Request is for Welchol packet for suspension;
2. Diagnosis of type 2 diabetes mellitus;
3. Age ≥ 18 years;
4. HbA1c drawn within the past 3 months is ≥ 6.5%;
5. Failure of adherent use of a triple anti-diabetic regimen which must include metformin in combination with agents from any of the following classes for ≥ 3 months, unless clinically significant adverse effects are experienced or all are contraindicated:†
   a. Glucagon-like peptide-1 (GLP-1) receptor agonist;
   b. Sodium glucose co-transporter 2 (SGLT-2) inhibitor;
   c. DPP-4 inhibitor;
   d. Thiazolidinedione (TZD);
   e. Basal insulin;

   †For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
6. At the time of request, current (within the last 3 months) serum triglyceride concentrations do not exceed 500 mg/dL;
7. If request is for brand Welchol packet for suspension, member must use generic colesevelam packet for suspension, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed oral suspension packet of 3.75 grams (1 packet) per day.

Approval duration: 12 months

C. 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 (health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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: HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (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;
3. If request is for brand Welchol packet for suspension, member must use generic colesevelam packet for suspension, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed oral suspension packet of 3.75 grams (1 packet) per day.

Approval duration: 12 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 (health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace/ICHRA and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: 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: 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 – HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DPP-4: dipeptidylpeptidase 4
FDA: Food and Drug Administration
GLP-1: glucagon-like peptide-1
HeFH: familial hypercholesterolemia
LDL-C: low-density lipoprotein cholesterol
SGLT-2: sodium glucose co-transporter-2
TZD: thiazolidinedione

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
colestipol (Colestid®)	**Primary Hyperlipidemia** Tablets: 2 g PO QD or BID Granules: 5 g PO QD or BID	Tablets: 16 g/day Granules: 30 g/day
cholestyramine (Questran®, Prevalite®)	**Primary Hyperlipidemia** 4 g PO QD or BID	24 g/day
metformin (e.g., Fortamet®, Glucophage®)	**Type 2 Diabetes Mellitus** Immediate-release: 500 mg to 850 mg PO QD to BID, then titrate up to 2,000 mg/day Extended-release: 500 mg to 1,000 mg PO QD, then titrate up to 2,000 mg/day	Immediate-release: 2,550 mg/day Extended-release: 2,000 to 2,500 mg/day depending on the formulation
GLP-1 receptor agonist (e.g., Victoza®, Trulicity®, Byetta®)	**Type 2 Diabetes Mellitus** *Refer to prescribing information*	*Refer to prescribing information*
SGLT-2 inhibitor (e.g., Jardiance®, Invokana®, Farxiga®)	**Type 2 Diabetes Mellitus** *Refer to prescribing information*	*Refer to prescribing information*
DPP-4 inhibitor (e.g., Januvia®, Onglyza®, Nesina®)	**Type 2 Diabetes Mellitus** *Refer to prescribing information*	*Refer to prescribing information*
TZD (e.g., pioglitazone, Avandia®)	**Type 2 Diabetes Mellitus** *Refer to prescribing information*	*Refer to prescribing information*
Basal insulin (e.g., insulin glargine)	**Type 2 Diabetes Mellitus** Varies	Varies
HMG-CoA reductase inhibitors (aka statins) (e.g.,	**Primary Hyperlipidemia** See Appendix D	*Refer to prescribing information*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
atorvastatin, rosuvastatin, lovastatin, etc,)		

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Serum triglyceride concentrations > 500 mg/dL
  - History of hypertriglyceridemia-induced pancreatitis
  - History of bowel obstruction
- Boxed warning(s): none reported

Appendix D: High, Moderate, and Low Intensity Statins

High	Moderate	Low
atorvastatin 40-80 mg rosuvastatin 20-40 mg	atorvastatin 10-20 mg fluvastatin XL 80 mg fluvastatin 40 mg twice daily lovastatin 40 mg pitavastatin 2-4 mg pravastatin 40-80 mg rosuvastatin 5-10 mg simvastatin 20-40 mg	fluvastatin 20-40 mg lovastatin 20 mg pitavastatin 1 mg pravastatin 10-20 mg simvastatin 10 mg

Appendix E: Statin Contraindications

- Decompensated liver disease (development of jaundice, ascites, variceal bleeding, encephalopathy)
- Laboratory-confirmed acute liver injury or rhabdomyolysis resulting from statin treatment
- Pregnancy, actively trying to become pregnant, or nursing
  - In July 2021, the FDA requested removal of the contraindication in pregnant patients. At the time of this review, statin manufacturers have not yet revised their labels. https://www.fda.gov/drugs/drug-safety-and-availability/fda-requests-removal-strongest-warning-against-using-cholesterol-lowering-statins-during-pregnancy
- Immune-mediated hypersensitivity to the HMG-CoA reductase inhibitor drug class (statins) as evidenced by an allergic reaction occurring with at least TWO different statins

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Primary hyperlipidemia and type 2 diabetes mellitus	Oral suspension packets: 3.75 g PO QD	Packet: 3.75 g/day

VI. Product Availability

- Tablet: 625 mg
- Oral suspension packet: 3.75 g

VII. References

1. Welchol Prescribing Information. Basking Ridge, NJ: Daiichi Sankyo Inc.; December 2024. Available at: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=89cbd0a3-2d1b-41db-8c97-35ec67b7b09f. Accessed July 10, 2026.
2. Grundy SM, Stone NJ, Bailey AL, et al. 2018 ACC/AHA/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Clinical Practice Guidelines. J Am Coll Cardiol 2018;Nov 10.
3. Blumenthal RS, Morris PB, Gaudino M, et al. 2026 ACC/AHA/AACVPR/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Dyslipidemia: A report of the American College of Cardiology/American Heart Association joint committee on clinical practice guidelines. J Am Coll Cardiol. 2026 Mar 13:S0735-1097(25)10254-4. doi: 10.1016/j.jacc.2025.11.016.
4. Samson SL, Vellanki P, Blonde L, et al. American Association of Clinical Endocrinology consensus statement: algorithm for management of adults with type 2 diabetes, 2026 update. *Endocr Pract.* 2026;32(4):473-518. doi:10.1016/j.eprac.2026.01.006.
5. American Diabetes Association Professional Practice Committee for Diabetes. Pharmacologic approaches to glycemic treatment: Standards of Care in Diabetes—2026. Diabetes Care. 2026;49(Suppl 1):S183-S215. doi:10.2337/dc26-S009.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: no significant changes; added redirection to generic; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	07.21.22	11.22
4Q 2023 annual review: updated limitations of use under FDA approved indication section to align with prescriber information; references reviewed and updated.	07.31.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	09.16.24	11.24
4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; extended initial approval duration from 6 months to 12 months as primary hyperlipidemia and type 2 diabetes mellitus are chronic conditions; 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

©2017 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.