odevixibat (BYLVAY)

Diagnoses Considered for Coverage:

- Treatment of pruritus in patients with progressive familial intrahepatic cholestasis (PFIC)
- Treatment of pruritus in patients with Alagille Syndrome (ALGS)

Coverage Criteria:

1. **For diagnosis of cholestatic pruritus, approve if:**
   - Prescribed by or in consultation with a hepatologist or GI specialist, **and**
   - Provider attestation that patient has progressive familial intrahepatic cholestasis (PFIC), **and**
   - Dose does not exceed 6 mg per day.

2. **For diagnosis of cholestatic pruritus due to Alagille Syndrome (ALGS), approve if:**
   - Being prescribed by or in consultation with a hepatologist or GI specialist, **and**
   - Provider attestation that patient has Alagille syndrome, **and**
   - Dose does not exceed 120 mcg/kg per day.

Coverage Duration: one year

Effective: 08/30/2023

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