

SPECIALTY GUIDELINE MANAGEMENT

TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

Trikafta is indicated for the treatment of cystic fibrosis (CF) in patients aged 2 years and older who have at least one *F508del* mutation in the cystic fibrosis transmembrane conductance regulator (*CFTR*) gene or a mutation in the *CFTR* gene that is responsive based on *in vitro* data.

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one *F508del* mutation or a mutation that is responsive based on *in vitro* data.

All other indications are considered experimental/investigational and not medically necessary.

II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review: For initial requests, genetic testing report confirming the presence of the appropriate *CFTR* gene mutation.

III. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a pulmonologist.

IV. CRITERIA FOR INITIAL APPROVAL

Cystic Fibrosis

Authorization of 12 months may be granted for treatment of cystic fibrosis when all of the following criteria are met:

- A. Genetic testing was conducted to detect a mutation in the *CFTR* gene.
- B. The member has one of the following mutations in the *CFTR* gene: A46D, A120T, A234D, A349V, A455E, A554E, A1006E, A1067T, D110E, D110H, D192G, D443Y, D443Y;G576A;R668C, D579G, D614G, D836Y, D924N, D979V, D1152H, D1270N, E56K, E60K, E92K, E116K, E193K, E403D, E474K, E588V, E822K, F191V, F311del, F311L, F508C, F508C;S1251N, F508del, F575Y, F1016S, F1052V, F1074L, F1099L, G27R, G85E, G126D, G178E, G178R, G194R, G194V, G314E, G463V, G480C, G551D, G551S, G576A, G576A;R668C, G622D, G628R, G970D, G1061R, G1069R, G1244E, G1249R, G1349D, H139R, H199Y, H939R, H1054D, H1085P, H1085R, H1375P, I148T, I175V, I336K, I502T, I601F, I618T, I807M, I980K, I1027T, I1139V, I1269N, I1366N, K1060T, L15P, L165S, L206W, L320V, L346P, L453S, L967S, L997F, L1077P, L1324P, L1335P, L1480P, M152V, M265R, M952I, M952T, M1101K, P5L, P67L, P205S,

| Reference number(s) |
|---------------------|
| 3374-A |

P574H, Q98R, Q237E, Q237H, Q359R, Q1291R, R31L, R74Q, R74W, R74W;D1270N, R74W;V201M, R74W;V201M;D1270N, R75Q, R117C, R117G, R117H, R117L, R117P, R170H, R258G, R334L, R334Q, R347H, R347L, R347P, R352Q, R352W, R553Q, R668C, R751L, R792G, R933G, R1066H, R1070Q, R1070W, R1162L, R1283M, R1283S, S13F, S341P, S364P, S492F, S549N, S549R, S589N, S737F, S912L, S945L, S977F, S1159F, S1159P, S1251N, S1255P, T338I, T1036N, T1053I, V201M, V232D, V456A, V456F, V562I, V754M, V1153E, V1240G, V1293G, W361R, W1098C, W1282R, Y109N, Y161D, Y161S, Y563N, Y1014C, Y1032C, 3141del9, 546insCTA.

- C. The member is at least 2 years of age.
- D. Trikafta will not be used in combination with other medications containing ivacaftor.

V. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section IV who are experiencing benefit from therapy as evidenced by disease stability or disease improvement (e.g., improvement in FEV1 from baseline).

VI. REFERENCES

1. Trikafta [package insert]. Boston, MA: Vertex Pharmaceuticals Inc; April 2023.