

Effective date: 1/1/2019
Review: 8/2019, 6/2020, 10/2020, 02/2021, 02/2022, 03/2023, 05/2023, 02/2024
Scope: Medicaid

SPECIALTY GUIDELINE MANAGEMENT

KALYDECO (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

Kalydeco is a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator indicated for the treatment of cystic fibrosis (CF) in patients aged 1 month and older who have one mutation in the *CFTR* gene that is responsive to ivacaftor potentiation based on clinical and/or *in vitro* assay data.

If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use.

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

II. DOCUMENTATION

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

III. CRITERIA FOR INITIAL APPROVAL

Cystic Fibrosis

Authorization of 6 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 medication is prescribed by or in consultation with a pulmonologist.
- C. The member has one of the following mutations in the *CFTR* gene : A120T, A234D, A349V, A455E, A1067T, D110E, D110H, D192G, D579G, D924N, D1152H, D1270N, E56K, E193K, E822K, E831X, F311del, F311L, F508C, F508C;S1251N, F1052V, F1074L, G178E, G178R, G194R, G314E, G551D, G551S, G576A, G970D, G1069R, G1244E, G1249R, G1349D, H939R, H1375P, I148T, I175V, I807M, I1027T, I1139V, K1060T, L206W, L320V, L967S, L997F, L1480P, M152V, M952I, M952T, P67L, Q237E, Q237H, Q359R, Q1291R, R74W, R75Q, R117C, R117G, R117H, R117L, R117P, R170H, R347H, R347L, R352Q, R553Q, R668C, R792G, R933G, R1070Q, R1070W, R1162L, R1283M, S549N, S549R, S589N, S737F, S945L, S977F, S1159F, S1159P,

Effective date: 1/1/2019
Review: 8/2019, 6/2020, 10/2020, 02/2021, 02/2022, 03/2023, 05/2023, 02/2024
Scope: Medicaid

S1251N, S1255P, T338I, T1053I, V232D, V562I, V754M, V1293G, W1282R, Y1014C, Y1032C, 711+3A→G, 2789+5G→A, 3272-26A→G, 3849+10kbC→T.

- D. The member is at least 1 months of age.
- E. Kalydeco will not be used in combination with other ivacaftor containing medications.
- F. The member does not have the F508del mutation on both alleles of the CFTR gene.
- G. If requesting granules, member is between 1 months of age through 5 years of age.

IV. CONTINUATION OF THERAPY

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

V. QUANTITY LIMIT

Kalydeco has a quantity limit of 2 tablets/packets per day.

VI. REFERENCES

1. Kalydeco [package insert]. Boston, MA: Vertex Pharmaceuticals Inc.; October 2023.
2. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Chronic medications for maintenance of lung health. *Am J Respir Crit Care Med.* 2013;187:680-689.