

<b>POLICY NAME</b>	Kalydeco (ivacaftor)	<b>POLICY #</b>	1962P
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## Criteria

### Exclusion Criteria – Any of the following prevents coverage

- ☐ 2.1 Member homozygous for F508del mutation in the CFTR gene

### Coverage Criteria for Kalydeco

- ☐ 1.1 Prescribed by a provider specializing in the treatment of cystic fibrosis
- ☐ 1.2 Member has a diagnosis of cystic fibrosis
- ☐ 1.3 Member is 1 month of age or older
- ☐ 1.4 Documentation of a CFTR gene mutation that produces the CFTR protein and is responsive to Kalydeco
- ☐ 1.5 Review of chart notes documenting diagnosis and confirming that patient has met all of the above requirements for treatment with Kalydeco by both a pharmacist and medical director