

POLICY NAME	Orkambi (lumacaftor/ivacaftor)	POLICY #	2391P
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Criteria

Coverage Criteria

- ☐ 1.1 Age 1 year or older
- ☐ 1.2 Prescribed by a pulmonologist (lung doctor)
- ☐ 1.3 Documented diagnosis of cystic fibrosis
 - Must be homozygous for the F508del mutation
- ☐ 1.4 Review of chart notes documenting diagnosis and confirming that patient has met all of the above requirements for treatment with Orkambi by both a pharmacist and medical director