Pharmacy Drug Policy Checklist

POLICY NAME	Kalydeco (ivacaftor)	POLICY #	1962P

Criteria

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

Exclusion Criteria – Any of the following prevents coverage

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