STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

Kalydeco® (Ivacaftor)
Prior Authorization Request Form

Prior authorization requests for Kalydeco will be authorized if the patient meets the following criteria:

1) Patient must be greater than two (2) years of age; **AND**

2) Documented diagnosis of cystic fibrosis with a *G551D*, *G1244E*, *G1349D*, *G178R*, *G551S*, *S1251N*, *S1255P*, *S549N*, *S549R* or *R117H* mutation in the CFTR gene; **AND**

3) Patient must NOT be homozygous for the F508del mutation in the CFTR gene; **AND**

4) Patient must NOT have concurrent therapy with rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin or St. John's Wort; **AND**

5) Dosage does not exceed 150 mg twice daily for ages 6 and up; **OR**

6) For patients ages 2 to less than 6 years, dosage should be weight-based and may not exceed 75 mg twice daily.

References:

1) Kalydeco® (package insert) Vertex Pharmaceuticals Inc., Boston, MA March 2015
2) Lexi-Comp drug monograph 5/26/2015

Reviewed and Approved May 21, 2014 (BMT)
Drug Utilization Review Board
Version 2 – Updated 5-26-2015 (BMT)