

**NC Medicaid  
Outpatient Pharmacy  
Prior Approval Criteria  
Cystic Fibrosis**

**Medicaid and Health Choice  
Effective Date: November 14, 2012  
Amended Date: ~~February 26, 2019~~**

**Therapeutic Class Code:** B0B, B0F

**Therapeutic Class Description:** CFTR (Cystic Fibrosis Transmembrane Conductance Regulator) Potentiator, and CFTR Potentiator and Corrector Combination

<b>Medication</b>	<b>Generic Code Number(s)</b>
Kalydeco 150mg tablets Kalydeco 50mg granules Kalydeco 75mg granules Kalydeco 25mg granules	31312, 38138, 38139, 46238
Orkambi 200mg/125mg tablets, Orkambi 100mg/125mg tablets, Orkambi 150/188mg granules Orkambi 100/125mg granules	39008, 42366, 42848, 36937
Symdeko 50mg/75mg tablets Symdeko 100/150 mg – 150 mg	44444, 46553

**Eligible Beneficiaries**

NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries.**

**EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of Age**

**42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

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Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at <https://medicaid.ncdhhs.gov>.

**Criteria for Coverage- Kalydeco:**

- Beneficiary has been diagnosed with Cystic Fibrosis **and**
- Beneficiary is age one or greater **and**
- Beneficiary has a documented G551D, G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, S549R, R117H, E56K, K1060T, P67L, E193K, A1067T, R74W, L206W, G1069R, D110E, R347H, D579G, R1070Q, D1270N, D110H, R352Q, S945L, R1070W, R117C, A455E, S977F, F1074L, F1052V, or D1152H mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. (KALYDECO is not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene) **and**
- Dosing is 150mg taken every 12 hours (300mg/day total) or less **and**
- A baseline ALT and AST assessed prior to beginning therapy

**Criteria for Coverage- Orkambi:**

- Beneficiary has been diagnosed with Cystic Fibrosis; **and**
- Beneficiary is age 6 or greater; **and**
- Beneficiary is documented as homozygous for the *F508del* mutation in the *CFTR* gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the *F508del* mutation on both alleles of the *CFTR* gene; **and**
- Dosing is two tablets (each containing lumacaftor 200 mg/ivacaftor 125 mg) or less taken orally every 12 hours with fat-containing food; **and**
- A baseline ALT and AST assessed prior to beginning therapy.

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**Criteria for Coverage- Symdeko:**

- Beneficiary has been diagnosed with Cystic Fibrosis; **and**
- Beneficiary is ~~12~~ **6** years of age or greater; **and**
- Beneficiary is documented as homozygous for the F508del mutation in the CFTR gene or beneficiary has one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene; **and**
- Dosing is one tablet (containing tezacaftor 100 mg/ivacaftor 150 mg) in the morning and one tablet (containing ivacaftor 150 mg) in the evening; **and**
- A baseline ALT and AST assessed prior to beginning therapy.

**Procedures:**

Length of therapy may be approved for up to 12 months.

**References**

1. Prescribing Information-Kalydeco® (ivacaftor) Vertex Pharmaceuticals, Inc., Cambridge, Massachusetts 02139. January 2012.
2. Prescribing Information Kalydeco®. Vertex Pharmaceuticals Incorporated Cambridge, MA; February 2014.
3. Prescribing Information Orkambi®. Vertex Pharmaceuticals Incorporated Boston, MA; April 2015.
4. Prescribing Information Orkambi®. Vertex Pharmaceuticals Incorporated Boston, MA; September 2016.
5. Prescribing Information Kalydeco®. Vertex Pharmaceuticals Incorporated Cambridge, MA; March 2015.
6. Prescribing Information Kalydeco®. Vertex Pharmaceuticals Incorporated Cambridge, MA; May 2017.
7. Prescribing Information Symdeko. Vertex Pharmaceuticals, Inc. Cambridge, MA; February 2018. **Revised June 2019.**

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**Criteria Change Log**

11/14/2012	Criteria effective date-Kalydeco only
08/01/2014	Added G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N, or S549R mutation in the CFTR gene. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. (KALYDECO is not effective in patients with CF who are homozygous for the F508del mutation in the CFTR gene)
04/01/2015	Added R117H mutation
11/05/2015	Added Kalydeco gcns 38138, 38139
03/09/2016	Added coverage for Orkambi
04/06/2017	Changed age for Kalydeco to 2 yrs and older and for Orkambi to 6 yrs and older
10/03/2017	Added genetic mutations E56K, K1060T, P67L, E193K, A1067T, R74W, L206W, G1069R, D110E, R347H, D579G, R1070Q, D1270N, D110H, R352Q, S945L, R1070W, R117C, A455E, S977F, F1074L, F1052V, or D1152H for Kalydeco
06/11/2018	Added information about Symdeko
02/26/2019	Age for Kalydeco changed from 2 or greater to 1 or greater
	Age for Symdeko changed from 12 or greater to 6 or greater. Updated GCN's with new products