PRIOR AUTHORIZATION POLICY

POLICY: Cystic Fibrosis – Orkambi Prior Authorization Policy
- Orkambi® (lumacaftor/ivacaftor tablets and oral granules – Vertex)

REVIEW DATE: 07/05/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Orkambi, a combination of lumacaftor and ivacaftor, is indicated for the treatment of **cystic fibrosis** in patients ≥ 1 year of age who are homozygous for the F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene.[1]

If the patient's genotype is unknown, an FDA-cleared cystic fibrosis mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene. The efficacy and safety of Orkambi have not been established in patients with cystic fibrosis other than those homozygous for the F508del mutation. Orkambi contains a unique chemical entity, lumacaftor, which is a CFTR corrector that increases trafficking of F508del CFTR to the cell surface, and ivacaftor (the same active ingredient contained in Kalydeco® [ivacaftor tablets and oral granules]), a CFTR potentiator that enhances chloride transport of CFTR on the cell surface. The F508del mutation in CFTR causes cystic fibrosis by limiting the amount of CFTR protein that reaches the epithelial cell surface.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Orkambi. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Orkambi as well as the

monitoring required for adverse events and long-term efficacy, approval requires Orkambi to be prescribed by or in consultation with a physician who specializes in the condition being treated.

- **Orkambi® (lumacaftor/ivacaftor tablets and oral granules – Vertex)**

is(are) covered as medically necessary when the following criteria is(are) met for fda-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. **Cystic Fibrosis, Homozygous for the F508del (Phe508del) Mutation in the Cystic Fibrosis Transmembrane Regulator (CFTR) Gene.** Approve for 1 year if the patient meets all of the following (A, B, and C):
   A) Patient is ≥ 1 year of age; AND
   B) Patient is homozygous for the F508del (Phe508del) mutation in the CFTR gene (meaning the patient has two copies of the F508del [Phe508del] mutation); AND
   C) The medication is prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.

CONDITIONS NOT COVERED

- **Orkambi® (lumacaftor/ivacaftor tablets and oral granules – Vertex)**

is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. **Cystic Fibrosis, Heterozygous for the F508del (Phe508del) Mutation in the CFTR Gene.** Orkambi is not indicated for patients with only one copy of the F508del mutation in the CFTR gene.[1]

2. **Combination Therapy with Kalydeco (ivacaftor tablets and oral granules), Symdeko (tezacaftor/ivacaftor; ivacaftor tablets, co-packaged), or Trikafta (elexacaftor/tezacaftor/ivacaftor tablets; ivacaftor tablets, co-packaged).** Orkambi contains ivacaftor, the active agent in Kalydeco and therefore is not indicated in combination with Kalydeco. Symdeko and Trikafta contain ivacaftor and are therefore not indicated in combination with Orkambi.

REFERENCES

1. Orkambi® tablets and oral granules [prescribing information]. Cambridge, MA: Vertex; September 2022.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	07/06/2022
Selected Revision	**Cystic Fibrosis (CF):** Age criteria were changed to approve in patients ≥ 1 year of age, previously ≥ 2 years of age.	09/07/2022
Annual Revision	No criteria changes.	07/05/2023