Kalydeco (ivacaftor) is a preferred product and will only be considered for coverage under the pharmacy benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

**CYSTIC FIBROSIS**

For initial authorization:
1. Member must be 2 years of age or older; AND
2. Medication must be prescribed by a pulmonologist or an infectious disease specialist; AND
4. Dosage allowed: Up to 150 mg every 12 hours.

If member meets all the requirements listed above, the medication will be approved for 3 months.

For reauthorization:
1. Member must be in compliance with all other initial criteria; AND
2. Member’s adherence to medication is confirmed by claims history.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Kalydeco (ivacaftor) not medically necessary for the treatment of the diseases that are not listed in this document.

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION/DESCRIPTION</th>
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<tbody>
<tr>
<td>06/12/2017</td>
<td>New policy for Kalydeco created. Not covered diagnosis added.</td>
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</tbody>
</table>

References:
Effective date: 08/09/2017
Revised date: 06/12/2017