UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 2060-14
Program	Prior Authorization/Medical Necessity
Medication	Orkambi™ (lumacaftor/ivacaftor)
P&T Approval Date	5/2015, 7/2016, 11/2016, 11/2017, 9/2018, 9/2019, 10/2020, 10/2021, 10/2022, 6/2023, 6/2024, 6/2025, 6/2026
Effective Date	9/1/2026

1. Background:

Orkambi is a combination of lumacaftor and ivacaftor, a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator, indicated for the treatment of cystic fibrosis (CF) in patients aged 1 year and older who are 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.

Limitations of Use:
The efficacy and safety of Orkambi have not been established in patients with CF other than those homozygous for the F508del mutation.

Members will be required to meet the coverage criteria below.

2. Coverage Criteria[a]:

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A. Initial Authorization

1. **Orkambi** will be approved based upon **all** of the following criteria:

   a. Diagnosis of cystic fibrosis (CF)

   -AND-

   b. Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the CFTR gene.

   -AND-

   c. The patient is ≥ 1 years of age

   -AND-

   d. Prescribed by or in consultation with a provider who specializes in the treatment of CF

Authorization will be issued for 12 months.

B. Reauthorization

1. **Orkambi** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Orkambi therapy (e.g., improved lung function, stable lung function)

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Orkambi [Package Insert]. Cambridge, MA: Vertex Pharmaceuticals, Inc.; March 2026.

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Program	Prior Authorization/Medical Necessity – Orkambi (lumacaftor/ivacaftor)
Change Control	
5/2015	New Program
7/2015	Revised implementation date for Oxford.
7/2016	Annual Review. Updated reference.
11/2016	Program updated modifying age restriction as label updated for pediatric use in patients aged 6 and older. Revised prescriber criterion. Updated reference.
11/2017	Annual Review. No changes.
9/2018	Program updated modifying age restriction as label updated for pediatric use in patients aged 2 and older.
9/2019	Annual review with no changes to coverage criteria.
10/2020	Annual review with no changes to coverage criteria. Updated reference.
10/2021	Annual review. Reauthorization approval duration updated from 24 months to 12 months.
10/2022	Annual review. Updated background and criteria with expanded indication in patients aged 1 to 2 years. Updated reference.
6/2023	Updated prescriber requirement and simplified reauthorization criteria. Updated reference.
6/2024	Annual review. Increased initial authorization approval duration to 12 months. Removed prescriber requirement from reauthorization criteria. Updated reference.
6/2025	Annual review. No changes to coverage criteria. Updated reference.
6/2026	Annual review. No changes to coverage criteria. Updated reference.

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