Louisiana Medicaid
Vanzacaftor/Tezacaftor/Deutivacaftor (Alyftrek™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for vanzacaftor/tezacaftor/deutivacaftor (Alyftrek™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

NOTE: This agent is a mutation-specific targeted therapy that is indicated to treat only the cystic fibrosis transmembrane conductance regulator (CFTR) mutation(s) listed in the prescribing information. Identification of the indicated genotype is required in order to receive treatment with this agent. If the recipient's genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of a CFTR mutation, followed by verification with bi-directional sequencing when recommended by the mutation test instructions.

Approval Criteria for Initiation of Therapy

- The recipient is 6 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of cystic fibrosis (CF) and **ONE** of the following is **stated on the request**:
    - The recipient has at least one *F508del* mutation; **OR**
    - The recipient has at least one mutation in the CFTR gene that is responsive to vanzacaftor/tezacaftor/deutivacaftor based on *in vitro* data and/or clinical evidence; **AND**
- If the request is for a non-preferred agent - **ONE** of the following is required: (See *Cystic Fibrosis, Oral* on the PDL/NPDL for list of preferred agents)
    - The recipient has had a *treatment failure* with at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred drug that is appropriate to use for the condition being treated; **OR**
    - The recipient has *documented contraindication(s)* to all preferred drugs that are appropriate to use for the condition being treated.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for initiation and continuation of therapy: 12 months

Reference

Alyftrek (vanzacaftor/tezacaftor/deutivacaftor) [package insert]. Boston, MA: Vertex Pharmaceuticals; January 2025. https://pi.vrtx.com/files/uspi_vanzacaftor_tezacaftor_deutivacaftor.pdf

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