HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Ivacaftor

INITIATION

Prerequisites (tick boxes where appropriate)

- ○ Patient has been diagnosed with cystic fibrosis

and

- ○ Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)

or

- ○ Patients must have a sweat chloride value of at least 60 mmol/L

and

- ○ Patient must have at least one mutation on the list of CFTR mutations that produce CFTR protein and are known to be responsive to ivacaftor**

and

- ○ Treatment with ivacaftor must be given concomitantly with standard therapy for this condition

and

- ○ The dose of ivacaftor will not exceed one tablet or one sachet twice daily

Note: ** Mutations listed in Table 3 of the Food and Drug Administration (FDA) Ivacaftor prescribing information https://www.accessdata.fda.gov/drugsatfda_docs/

I confirm that the above details are correct:

Signed: ..... Date: .....