

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Vanzacaftor with tezacaftor and deutivacaftor**

**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
- Patient has a sweat chloride value of at least 60 mmol/L
- and
- Patient has a heterozygous or homozygous F508del mutation
- or
- Patient has a mutation responsive to vanzacaftor/tezacaftor/deutivacaftor (see note)
- and
- The treatment must be the sole funded CFTR modulator therapy for this condition
- and
- Treatment with vanzacaftor/tezacaftor/deutivacaftor must be given concomitantly with standard therapy for this condition

Note: Eligible mutations are listed in the in the Food and Drug Administration (FDA) Alyftrek prescribing information <https://www.accessdata.fda.gov/drugsatfda>

I confirm that the above details are correct:

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