

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Ivacaftor

Initial application

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been diagnosed with cystic fibrosis
and	
<input type="checkbox"/>	Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
or	
<input type="checkbox"/>	Patients must have a sweat chloride value of at least 60 mmol/L
and	
<input type="checkbox"/>	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	
<input type="checkbox"/>	Treatment with ivacaftor must be given concomitantly with standard therapy for this condition
and	
<input type="checkbox"/>	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 the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz