Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2650
June 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Ivacaftor

Initial application
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
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 has a mutation responsive to ivacaftor (see note)

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/lab

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