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					PATIENT:
Name	e:				Name:
Ward	:				NHI:
Ivacaftor					
INITIATION					
Prerequisites (tick boxes where appropriate)					
and		Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.			
	and	0	Patie	nt has been diagnosed with cystic fibrosis	
	and and and and	or	0	Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele	
			0	Patient must have other gating (class III) mutation (G124 in the CFTR gene on at least 1 allele	4E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R)
		0		nts must have a sweat chloride value of at least 60 mmol/ ction system	L by quantitative pilocarpine iontophoresis or by Macroduct sweat
		0		ment with ivacaftor must be given concomitantly with stan	dard therapy for this condition
		0		nt must not have an acute upper or lower respiratory infectiotics) for pulmonary disease in the last 4 weeks prior to co	tion, pulmonary exacerbation, or changes in therapy (including ommencing treatment with ivacaftor
		0	The o	dose of ivacaftor will not exceed one tablet or one sachet t	wice daily
		\circ	Appli	cant has experience and expertise in the management of	cystic fibrosis