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.

PRESCRIE	BER		PATIE	NT:		
Name:						
Ward:						
Elexacaf	tor	with	n tezacaftor, ivacaftor and ivacaftor			
INITIATIO Prerequis		(tick b	boxes where appropriate)			
and	0	Patient has been diagnosed with cystic fibrosis				
and	0	Patie	Patient is 6 years of age or older			
		0	O Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)			
	or	0	Patient has a sweat chloride value of at least 60 mmol/L by qua	antitative pilocarpine iontophoresis or by Macroduct sweat		
and		\sim				
	or	\bigcirc	Patient has a heterozygous or homozygous F508del mutation			
		\circ	Patient has a G551D mutation or other mutation responsive in v	itro to elexacaftor/tezacaftor/ivacaftor (see note a)		
and	0	The t	treatment must be the sole funded CFTR modulator therapy for the	nis condition		
and	Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition					
Note:						
a) Eligible https://	mut	ations crs.fda	ns are listed in the Food and Drug Administration (FDA) Trikafta pr da.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3	escribing information aee135d8d/spl-doc		

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
Oigilica.	 Daic.	