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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Ivacaftor

INITIATION

Prerequisites (tick boxes where appropriate)

❍ 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

❍ Patient has been diagnosed with cystic fibrosis

and

❍ Patient must have G551D mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene on at least 1 allele

or

❍ Patient must have other gating (class III) mutation (G1244E, G1349D, G178R, G551S, S1251N, S1255P, S549N and S549R) in the CFTR gene on at least 1 allele

and

❍ Patients must have a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system

and

❍ Treatment with ivacaftor must be given concomitantly with standard therapy for this condition

and

❍ Patient must not have an acute upper or lower respiratory infection, pulmonary exacerbation, or changes in therapy (including antibiotics) for pulmonary disease in the last 4 weeks prior to commencing treatment with ivacaftor

and

❍ The dose of ivacaftor will not exceed one tablet or one sachet twice daily

and

❍ Applicant has experience and expertise in the management of cystic fibrosis

I confirm that the above details are correct:

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