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.

PRESCRIBE	R		PATIENT:
Name:			Name:
Ward:			NHI:
Elexacafto	or v	with	tezacaftor, ivacaftor and ivacaftor
INITIATION Prerequisit		(tick b	poxes where appropriate)
and)	Patie	ent has been diagnosed with cystic fibrosis
and)	Patie	ent is 6 years of age or older
		0	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 quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
and			
		\circ	Patient has a heterozygous or homozygous F508del mutation
	or	0	Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
and and)	The t	treatment must be the sole funded CFTR modulator therapy for this condition
)	Treat	tment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition
Note:			
a) Eligible r	muta ctr-c	ations	s are listed in the Food and Drug Administration (FDA) Trikafta prescribing information a.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc

I confirm that the above details are correct:

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