

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: NHI:

Elexacaftor with tezacaftor, ivacaftor and ivacaftor

INITIATION

Prerequisites (tick boxes where appropriate)

and Patient has been diagnosed with cystic fibrosis
and Patient is 6 years of age or older
and Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
or Patient has a sweat chloride value of at least 60 mmol/L by quantitative pilocarpine iontophoresis or by Macroduct sweat collection system
and Patient has a heterozygous or homozygous F508del mutation
or Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)
and The treatment must be the sole funded CFTR modulator therapy for this condition
and Treatment with elexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition

Note:

a) Eligible mutations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information
<https://nctr-crs.fda.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc>

I confirm that the above details are correct:

Signed: Date: