

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:

Name:

Ward:

NHI:

Ivacaftor

INITIATION

Prerequisites (tick boxes where appropriate)

- Patient has been diagnosed with cystic fibrosis
- and
- Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
- or
- Patients must have a sweat chloride value of at least 60 mmol/L
- and
- Patient must have at least one mutation on the list of CFTR mutations that produce CFTR protein and are known to be responsive to ivacaftor**
- and
- Treatment with ivacaftor must be given concomitantly with standard therapy for this condition
- and
- The dose of ivacaftor will not exceed one tablet or one sachet twice daily

Note: ** Mutations listed in Table 3 of the Food and Drug Administration (FDA) Ivacaftor prescribing information https://www.accessdata.fda.gov/drugsatfda_docs/

I confirm that the above details are correct:

Signed: Date: