

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:

Ellexacaftor with tezacaftor, ivacaftor and 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
- ☐ Patient has a sweat chloride value of at least 60 mmol/L
- and
- ☐ Patient has a heterozygous or homozygous F508del mutation
- or
- ☐ Patient has a mutation responsive to ellexacaftor/tezacaftor/ivacaftor (see note)
- and
- ☐ The treatment must be the sole funded CFTR modulator therapy for this condition
- and
- ☐ Treatment with ellexacaftor/tezacaftor/ivacaftor must be given concomitantly with standard therapy for this condition

Note: Eligible mutations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/212829Orig1s010.pdf

I confirm that the above details are correct:

Signed: Date: