

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Ivacaftor**

**Initial application**

Applications only from a respiratory specialist or paediatrician. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- 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 the above details are correct and that in signing this form I understand I may be audited.

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

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)