

<b>APPLICANT</b> (stamp or sticker acceptable)	<b>PATIENT</b> NHI: .....	<b>REFERRER</b> Reg No: .....
Reg No: .....	First Names: .....	First Names: .....
Name: .....	Surname: .....	Surname: .....
Address: .....	DOB: .....	Address: .....
.....	Address: .....	.....
.....	.....	.....
Fax Number: .....	.....	Fax Number: .....

**Elexacaftor with tezacaftor, ivacaftor and ivacaftor**

**Initial application**

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

**Prerequisites**(tick boxes where appropriate)

- ☐ 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 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)