

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	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)

and Patient has been diagnosed with cystic fibrosis

and Patient is 6 years of age or older

and

or 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 Macrodust sweat collection system

and

or 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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz