

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

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

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