

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