

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

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient has been diagnosed with cystic fibrosis
<b>and</b>	
<input type="checkbox"/>	Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele)
<b>or</b>	
<input type="checkbox"/>	Patients must have a sweat chloride value of at least 60 mmol/L
<b>and</b>	
<input type="checkbox"/>	Patient must have at least one mutation on the list of CFTR mutations that produce CFTR protein and are known to be responsive to ivacaftor**
<b>and</b>	
<input type="checkbox"/>	Treatment with ivacaftor must be given concomitantly with standard therapy for this condition
<b>and</b>	
<input type="checkbox"/>	The dose of ivacaftor will not exceed one tablet or one sachet twice daily

Note: \*\* Mutations listed in Table 3 of the Food and Drug Administration (FDA) Ivacaftor prescribing information [https://www.accessdata.fda.gov/drugsatfda\\_docs/](https://www.accessdata.fda.gov/drugsatfda_docs/)

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](mailto:customerservice@health.govt.nz)