

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:

Vanzacaftor with tezacaftor and deutivacaftor

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 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

and

Patient has a heterozygous or homozygous F508del mutation

or

Patient has a mutation responsive to vanzacaftor/tezacaftor/deutivacaftor (see note)

and

The treatment must be the sole funded CFTR modulator therapy for this condition

and

Treatment with vanzacaftor/tezacaftor/deutivacaftor must be given concomitantly with standard therapy for this condition

Note: Eligible mutations are listed in the in the Food and Drug Administration (FDA) Alyftrek prescribing information https://www.accessdata.fda.gov/drugsatfda_d

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