

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 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 and <input type="checkbox"/> Patient has two cystic fibrosis-causing mutations in the cystic fibrosis transmembrane regulator (CFTR) gene (one from each parental allele) or <input type="checkbox"/> Patients must have a sweat chloride value of at least 60 mmol/L and <input type="checkbox"/> Patient has a mutation responsive to ivacaftor (see note) and <input type="checkbox"/> Treatment with ivacaftor must be given concomitantly with standard therapy for this condition and <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/lab

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