

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:	
.....		
.....		

Ivacaftor

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	
☐	Patients must have a sweat chloride value of at least 60 mmol/L
and	
☐	Patient has a mutation responsive to ivacaftor (see note)
and	
☐	Treatment with ivacaftor must be given concomitantly with standard therapy for this condition
and	
☐	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