

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Azithromycin

INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections

Prerequisites (tick boxes where appropriate)

- Patient has received a lung transplant, stem cell transplant or bone marrow transplant and requires treatment for bronchiolitis obliterans syndrome*
- or
- Patient has received a lung transplant and requires prophylaxis for bronchiolitis obliterans syndrome*
- or
- Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas related gram negative organisms*
- or
- Patient has an atypical Mycobacterium infection

Note: Indications marked with * are unapproved indications

INITIATION – non-cystic fibrosis bronchiectasis*

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and
- For prophylaxis of exacerbations of non-cystic fibrosis bronchiectasis*
- and
- Patient is aged 18 and under
- and
- or
 - Patient has had 3 or more exacerbations of their bronchiectasis, within a 12 month period
 - or
 - Patient has had 3 acute admissions to hospital for treatment of infective respiratory exacerbations within a 12 month period

Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community.

CONTINUATION – non-cystic fibrosis bronchiectasis*

Re-assessment required after 12 months

Prerequisites (tick boxes where appropriate)

- Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and
- The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis
- and
- Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment
- and
- The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note)

Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community.

INITIATION – other indications

Re-assessment required after 5 days

Prerequisites (tick box where appropriate)

- For any other condition

I confirm that the above details are correct:

Signed: Date:

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to [Section H](#) of the Pharmaceutical Schedule. For community funding, see the [Special Authority Criteria](#).

PRESCRIBER

PATIENT:

Name:

Name:

Ward:

NHI:

Azithromycin - *continued*

CONTINUATION – other indications

Re-assessment required after 5 days

Prerequisites (tick box where appropriate)

For any other condition

HOSPITAL

I confirm that the above details are correct:

Signed: Date: