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: .....

Posaconazole

INITIATION
Re-assessment required after 6 weeks
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ Patient has acute myeloid leukaemia

or

- ○ Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection

and

- ○ Patient is to be treated with high dose remission induction therapy or re-induction therapy

CONTINUATION
Re-assessment required after 6 weeks
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ○ Patient has previously received posaconazole prophylaxis during remission induction therapy

and

- ○ Patient is to be treated with high dose remission re-induction therapy

or

- ○ Patient is to be treated with high dose consolidation therapy

or

- ○ Patient is receiving a high risk stem cell transplant

I confirm that the above details are correct:

Signed: ..... Date: .....