

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:

Caspofungin

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Te Whatu Ora Hospital.

and

- ☐ Proven or probable invasive fungal infection, to be prescribed under an established protocol

or

and

- ☐ Possible invasive fungal infection
- ☐ A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

I confirm that the above details are correct:

Signed: Date: