# HOSPITAL MEDICINES LIST
# RESTRICTIONS CHECKLIST



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**

- ○ 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: .....

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Azithromycin *- continued*

**CONTINUATION – 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: .....