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: .....

Letermovir

INITIATION – Cytomegalovirus prophylaxis post HSCT
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone an allogeneic haematopoietic stem cell transplant

and

- ○ Patient is at high risk of cytomegalovirus disease or reactivation

and

- ○ Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant

and

- ○ Maximum treatment duration of 100 days post-transplant

CONTINUATION – Cytomegalovirus prophylaxis second or subsequent HSCT
Re-assessment required after 4 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone an allogeneic haematopoietic stem cell transplant

and

- ○ Patient is at high risk of cytomegalovirus disease or reactivation

and

- ○ Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant

and

- ○ Maximum treatment duration of 100 days post-transplant

INITIATION – CMV prophylaxis in severe immunosuppression*
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has severe immunosuppression requiring prophylaxis of CMV

and

- ○ Patient is contraindicated to all other funded CMV active oral antiviral agents

or

- ○ Patients CMV is resistant to all other funded CMV active oral antiviral agents

CONTINUATION – CMV prophylaxis in severe immunosuppression*
Re-assessment required after 6 months
Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ Patient has severe immunosuppression requiring prophylaxis of CMV

and

- ○ Patient is contraindicated to all other funded CMV active oral antiviral agents

or

- ○ Patients CMV is resistant to all other funded CMV active oral antiviral agents

Note: Indications marked with * are unapproved indications.

I confirm that the above details are correct:

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

HOSPITAL