

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 Health NZ 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 Health NZ 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: