

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:

Voriconazole

INITIATION – Proven or probable aspergillus infection

Prerequisites (tick boxes where appropriate)

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

and

Patient is immunocompromised

and

Patient has proven or probable invasive aspergillus infection

INITIATION – Possible aspergillus infection

Prerequisites (tick boxes where appropriate)

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

and

Patient is immunocompromised

and

Patient has possible invasive aspergillus infection

and

A multidisciplinary team (including an infectious disease physician) considers the treatment to be appropriate

INITIATION – Resistant candidiasis infections and other moulds

Prerequisites (tick boxes where appropriate)

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

and

Patient is immunocompromised

and

Patient has fluconazole resistant candidiasis

or

Patient has mould strain such as *Fusarium* spp. and *Scedosporium* spp

and

A multidisciplinary team (including an infectious disease physician or clinical microbiologist) considers the treatment to be appropriate

I confirm that the above details are correct:

Signed: Date: