I confirm that the above details are correct:

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

## HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

March 2025

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	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin	
INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections  Prerequisites (tick boxes where appropriate)	
or O Patient has received a lung transplant and requires prophylaxi	bone marrow transplant and requires treatment for bronchiolitis is for bronchiolitis obliterans syndrome* domonas aeruginosa or Pseudomonas related gram negative organisms*
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 paedia endorsed by the Health NZ Hospital.  To prophylaxis of exacerbations of non-cystic fibrosis bronchi and  Patient is aged 18 and under  Patient has had 3 or more exacerbations of their bronch	iectasis*
Patient has had 3 acute admissions to hospital for treatr  Note: Indications marked with * are unapproved indications. A maximum of 2 in the community.	ment of infective respiratory exacerbations within a 12 month period  44 months of azithromycin treatment for non-cystic fibrosis will be subsidised
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.  The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis  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  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	

## 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	PATIENT:
Name:	Name:
Ward:	NHI:
Azithromycin - continued	
CONTINUATION – other indications Re-assessment required after 5 days	
Prerequisites (tick box where appropriate)	
O For any other condition	

I confirm that the above details are correct:

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