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: .....

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

INITIATION – Invasive fungal infection prophylaxis

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- ○ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- ○ The patient is at risk of invasive fungal infection

and

- ○ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

- ○ Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

I confirm that the above details are correct:

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

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 *- continued*

CONTINUATION – Invasive fungal infection prophylaxis
Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

❍ Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

❍ The patient is at risk of invasive fungal infection

and

❍ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

❍ Prescribing voriconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

I confirm that the above details are correct:

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