HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

May 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	e:			Name:					
Ward	:			NHI:					
Voriconazole									
	NITIATION – Proven or probable aspergillus infection Prerequisites (tick boxes where appropriate)								
and		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	0	Patient is immunocompromised Patient has proven or probable invasive aspergillus infection						
INITIATION – Possible aspergillus infection Prerequisites (tick boxes where appropriate)									
and	Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protoco guideline that has been endorsed by the Health NZ Hospital.								
		0	Patient is immunocompromised						
	and	0	Patient has possible invasive aspergillus infection						
	and		A multidisciplinary team (including an infectious disease physic	cian) considers the treatment to be appropriate					
INITIATION – Resistant candidiasis infections and other moulds Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or									
and	origination inheritation disease specialist, of in accordance with a protector of								
	and	O	Patient is immunocompromised						
			O Patient has fluconazole resistant candidiasis						
		or	O Patient has mould strain such as Fusarium spp. and Sco	edosporium spp					
	and	O	A multidisciplinary team (including an infectious disease physic	cian 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) Or 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	and	O	The patient is at risk of invasive fungal infection						
		or	paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,					
			O Prescribing voriconazole is in accordance with a protoco	ol or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)					

I confirm that the above details are correct:

Signed: Date:

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER					PATIENT:				
Name:					Name:				
Ward:					NHI:				
Vorio	Voriconazole - continued								
CONTINUATION – Invasive fungal infection prophylaxis Re-assessment required after 6 months									
Prer	equisi	ites ((tick b	oxes where appropriate)					
(and	Prescribed by, or recommended by any relevant practitioner, or in accordance with a protocol or guideline that has been endorsed by the He NZ Hospital.								
	(and	O The patient is at risk of invasive fungal infection							
		or	0	Voriconazole is prescribed by, or recommended by a hae paediatric haematologist or paediatric oncologist	ematologist, transplant physician, infectious disease specialist,				
			0	Prescribing voriconazole is in accordance with a protocol Whatu Ora Hospital in the specific settings where there is	or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)				

I confirm that the above details are correct:	
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