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:		
Casp	ofu	ngin					
	TIATION  erequisites (tick boxes where appropriate)  Prescribed by, or recommended by a clinical microbiologist, haematologist, infectious disease specialist, oncologist, respiratory specialist or transplant specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
	or	O F	Proven or probable invasive fungal infection, to be prescribed under an established protocol  O Possible invasive fungal infection		under an established protocol		
			O 	A multidisciplinary team (including an infectious disease appropriate	physician or a clinical microbiologist) considers the treatment to be		

C:	D-1	
Signed.	Date:	
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