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: .....

Posaconazole

INITIATION
Re-assessment required after 6 weeks
Prerequisites (tick boxes where appropriate)

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

and

- ○ Patient has acute myeloid leukaemia

or

- ○ Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection

and

- ○ Patient is to be treated with high dose remission induction therapy or re-induction therapy

CONTINUATION
Re-assessment required after 6 weeks
Prerequisites (tick boxes where appropriate)

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

and

- ○ Patient has previously received posaconazole prophylaxis during remission induction therapy

and

- ○ Patient is to be treated with high dose remission re-induction therapy

or

- ○ Patient is to be treated with high dose consolidation therapy

or

- ○ Patient is receiving a high risk stem cell transplant

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

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

or

- ○ Prescribing posaconazole 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: .....

Posaconazole *- 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

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

or

❍ Prescribing posaconazole 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: .....