# 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: .....