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: .....

Caspofungin

INITIATION

Prerequisites (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.

and

❍ Proven or probable invasive fungal infection, to be prescribed under an established protocol

or

❍ Possible invasive fungal infection

and

❍ A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

I confirm that the above details are correct:

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