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 | PATIENT: |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| Name: | Name: |
| Ward: | NHI: |
| Azithromycin | |
| INITIATION – bronchiolitis obliterans syndrome, cystic fibrosis and atypical Mycobacterium infections Prerequisites (tick boxes where appropriate) | |
| Patient has received a lung transplant, stem cell transplant or be obliterans syndrome* Patient has received a lung transplant and requires prophylaxis or Patient has systic fibracia and has absonic infaction with Page | |
| or Patient has an atypical Mycobacterium infection | omonas aeruginosa or Eseudomonas related grain negative organisms |
| Note: Indications marked with * are unapproved indications | |
| INITIATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) O Prescribed by, or recommended by a respiratory specialist or paediate endorsed by the Health NZ Hospital. | trician, or in accordance with a protocol or guideline that has been |
| For prophylaxis of exacerbations of non-cystic fibrosis bronchie and Patient is aged 18 and under and Patient has had 3 or more exacerbations of their bronchi Patient has had 3 acute admissions to hospital for treatm | |
| Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community. | |
| CONTINUATION – non-cystic fibrosis bronchiectasis* Re-assessment required after 12 months Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a respiratory specialist or paediatrician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital. The patient has completed 12 months of azithromycin treatment for non-cystic fibrosis bronchiectasis Following initial 12 months of treatment, the patient has not received any further azithromycin treatment for non-cystic fibrosis bronchiectasis for a further 12 months, unless considered clinically inappropriate to stop treatment The patient will not receive more than a total of 24 months' azithromycin cumulative treatment (see note) Note: Indications marked with * are unapproved indications. A maximum of 24 months of azithromycin treatment for non-cystic fibrosis will be subsidised in the community. | |
| Re-assessment required after 5 days Prerequisites (tick box where appropriate) | |
| O For any other condition | |

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HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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: |
| Azithromycin - continued | |
| CONTINUATION – other indications Re-assessment required after 5 days | |
| Prerequisites (tick box where appropriate) | |
| O For any other condition | |

