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: .....

Valganciclovir

INITIATION – Transplant cytomegalovirus prophylaxis
Re-assessment required after 3 months
Prerequisites (tick box where appropriate)

- ○ Patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis

CONTINUATION – Transplant cytomegalovirus prophylaxis
Re-assessment required after 3 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis
- **and**
- ○ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin

or

- ○ Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis
- **and**
- ○ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone

INITIATION – Lung transplant cytomegalovirus prophylaxis
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone a lung transplant
- **and**
- ○ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative
- **or**
- ○ The recipient is cytomegalovirus positive
- **and**
- ○ Patient has a high risk of CMV disease

CONTINUATION – Lung transplant cytomegalovirus prophylaxis
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has undergone a lung re-transplant
- **and**
- ○ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative
- **or**
- ○ The recipient is cytomegalovirus positive
- **and**
- ○ Patient has a high risk of CMV disease

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: .....

Valganciclovir *- continued*

INITIATION – Cytomegalovirus in immunocompromised patients

Prerequisites (tick boxes where appropriate)

❍ Patient is immunocompromised

and

❍ Patient has cytomegalovirus syndrome or tissue invasive disease

or

❍ Patient has rapidly rising plasma CMV DNA in absence of disease

or

❍ Patient has cytomegalovirus retinitis

I confirm that the above details are correct:

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