## 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.

PRES	CRII	BER			PATIENT:			
Name:					Name:			
Ward:	:				NHI:			
Posa	cor	nazo	le					
	sses	smen		nired after 6 weeks poxes where appropriate)				
and				by, or recommended by a haematologist or infectious dis by the Health NZ Hospital.	ease specialist, or in accordance with a protocol or guideline that has been			
	and	or	O O	Patient has acute myeloid leukaemia  Patient is planned to receive a stem cell transplant and i	s at high risk for aspergillus infection			
		0	Patient is to be treated with high dose remission induction therapy or re-induction therapy					
Re-a	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 be endorsed by the Health NZ Hospital.  Patient has previously received posaconazole prophylaxis during remission induction therapy							
	and	or or	O O O	Patient is to be treated with high dose remission re-induced Patient is to be treated with high dose consolidation there are patient is receiving a high risk stem cell transplant				
Re-a	sses equi:	smen <b>sites</b>	t requ (tick b cribed		cordance with a protocol or guideline that has been endorsed by the Health			
	and	O	The O	paediatric haematologist or paediatric oncologist  Prescribing posaconazole is in accordance with a protoc	aematologist, transplant physician, infectious disease specialist, col or guideline that has been endorsed by the Health New Zealand - Te is a greater than 10% risk of invasive fungal infection (IFI)			

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	R			PATIENT:
				Name:
				NHI:
na	zole	<b>e</b> - c	ontinued	
ssm <b>site</b> Pre	ent r e <b>s</b> (tid	requi ick b bed l	red after 6 months  oxes where appropriate)  by, or recommended by any relevant practitioner, or in acc	cordance with a protocol or guideline that has been endorsed by the Health
O The patient is at risk of invasive fungal infection				
	(	O Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist		nematologist, transplant physician, infectious disease specialist,
	(		Prescribing posaconazole is in accordance with a protoc Whatu Ora Hospital in the specific settings where there is	ol or guideline that has been endorsed by the Health New Zealand - Te s a greater than 10% risk of invasive fungal infection (IFI)
	Pre NZ	DATION SITES (to Prescri NZ Hos	Prescribed NZ Hospital	DATION – Invasive fungal infection prophylaxis isment required after 6 months sites (tick boxes where appropriate)  Prescribed by, or recommended by any relevant practitioner, or in account NZ Hospital.  The patient is at risk of invasive fungal infection  Posaconazole is prescribed by, or recommended by a hapaediatric haematologist or paediatric oncologist  Prescribing posaconazole is in accordance with a protoco

I confirm that the above details are correct:	
Signed:	Date: