

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:

Posaconazole

INITIATION

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 been endorsed by the Health NZ Hospital.

and

- ☐ Patient has acute myeloid leukaemia
or
☐ Patient is planned to receive a stem cell transplant and is at high risk for aspergillus infection

and

- ☐ Patient is to be treated with high dose remission induction therapy or re-induction therapy

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 been endorsed by the Health NZ Hospital.

and

- ☐ Patient has previously received posaconazole prophylaxis during remission induction therapy

and

- ☐ Patient is to be treated with high dose remission re-induction therapy
or
☐ Patient is to be treated with high dose consolidation therapy
or
☐ Patient is receiving a high risk stem cell transplant

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

- ☐ Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
or
☐ Prescribing posaconazole 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:

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PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Posaconazole - *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

- ☐ Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
- or
- ☐ Prescribing posaconazole 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: