

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:

Moxifloxacin

INITIATION – Mycobacterium infection

Prerequisites (tick boxes where appropriate)

☐ Prescribed by, or recommended by an infectious disease specialist, clinical microbiologist or respiratory specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ Active tuberculosis

and

☐ Documented resistance to one or more first-line medications

or

☐ Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents

or

☐ Impaired visual acuity (considered to preclude ethambutol use)

or

☐ Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications

or

☐ Significant documented intolerance and/or side effects following a reasonable trial of first-line medications

or

☐ Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated

or

☐ Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case

INITIATION – Pneumonia

Prerequisites (tick boxes where appropriate)

☐ Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ Immunocompromised patient with pneumonia that is unresponsive to first-line treatment

or

☐ Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics

INITIATION – Penetrating eye injury

Prerequisites (tick box where appropriate)

☐ Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ Five days treatment for patients requiring prophylaxis following a penetrating eye injury

INITIATION – Mycoplasma genitalium

Prerequisites (tick boxes where appropriate)

☐ Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic

and

☐ Has tried and failed to clear infection using azithromycin

or

☐ Has laboratory confirmed azithromycin resistance

and

☐ Treatment is only for 7 days

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

Name:

Ward:

PATIENT:

Name:

NHI:

Moxifloxacin - *continued*

INITIATION – severe delayed beta-lactam allergy

Prerequisites (tick box where appropriate)

☐ Prescribed by, or recommended by an infectious disease specialist or clinical microbiologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

☐ Individual has a history of severe delayed beta-lactam allergy

I confirm that the above details are correct:

Signed: Date: