

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: NHI:

PATIENT:

Name:

Zanamivir - Powder for inhalation 5 mg

INITIATION

Prerequisites (tick boxes where appropriate)

or

- Only for hospitalised patient with known or suspected influenza
- For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan

I confirm that the above details are correct:

Signed: Date: