

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:

COVID-19 treatments

INITIATION

Prerequisites (tick box where appropriate)

- ☐ Only if patient meets access criteria (as per <https://pharmac.govt.nz/covid-oral-antivirals>). Note the supply of treatment is via Pharmac's approved distribution process. Refer to the Pharmac website for more information about this and stock availability

I confirm that the above details are correct:

Signed: Date: