

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: Name:

Ward: 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:

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: Name:

Ward: 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: