

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: .....

**Voriconazole**

**INITIATION – Proven or probable aspergillus infection**

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
**and**  
 Patient is immunocompromised  
**and**  
 Patient has proven or probable invasive aspergillus infection

**INITIATION – Possible aspergillus infection**

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
**and**  
 Patient is immunocompromised  
**and**  
 Patient has possible invasive aspergillus infection  
**and**  
 A multidisciplinary team (including an infectious disease physician) considers the treatment to be appropriate

**INITIATION – Resistant candidiasis infections and other moulds**

**Prerequisites** (tick boxes where appropriate)

Prescribed by, or recommended by a clinical microbiologist, haematologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.  
**and**  
 Patient is immunocompromised  
**and**  
 Patient has fluconazole resistant candidiasis  
**or**  
 Patient has mould strain such as Fusarium spp. and Scedosporium spp.  
**and**  
 A multidisciplinary team (including an infectious disease physician or clinical microbiologist) considers the treatment to be appropriate

**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**  
 Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist  
**or**  
 Prescribing voriconazole 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: ..... Name: .....

Ward: ..... NHI: .....

**Voriconazole - 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

Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

Prescribing voriconazole 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: .....