

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: .....

**Caspofungin**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

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

**and**

Proven or probable invasive fungal infection, to be prescribed under an established protocol

**or**

**and**

Possible invasive fungal infection

A multidisciplinary team (including an infectious disease physician or a clinical microbiologist) considers the treatment to be appropriate

I confirm that the above details are correct:

Signed: ..... Date: .....