

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: .....

**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**

**PATIENT:**

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: .....