

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: .....

**Moxifloxacin**

**INITIATION – Mycobacterium infection**

**Prerequisites** (tick boxes where appropriate)

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

and

- Active tuberculosis

and

- Documented resistance to one or more first-line medications  
or  
 Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents  
or  
 Impaired visual acuity (considered to preclude ethambutol use)  
or  
 Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications  
or  
 Significant documented intolerance and/or side effects following a reasonable trial of first-line medications

or

- Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated

or

- Patient is under five years of age and has had close contact with a confirmed multi-drug resistant tuberculosis case

**INITIATION – Pneumonia**

**Prerequisites** (tick boxes where appropriate)

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

and

- Immunocompromised patient with pneumonia that is unresponsive to first-line treatment  
or  
 Pneumococcal pneumonia or other invasive pneumococcal disease highly resistant to other antibiotics

**INITIATION – Penetrating eye injury**

**Prerequisites** (tick box where appropriate)

- Prescribed by, or recommended by an ophthalmologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.

and

- Five days treatment for patients requiring prophylaxis following a penetrating eye injury

**INITIATION – Mycoplasma genitalium**

**Prerequisites** (tick boxes where appropriate)

- Has nucleic acid amplification test (NAAT) confirmed Mycoplasma genitalium and is symptomatic

and

- Has tried and failed to clear infection using azithromycin  
or  
 Has laboratory confirmed azithromycin resistance

and

- Treatment is only for 7 days

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Moxifloxacin** - *continued*

**INITIATION – severe delayed beta-lactam allergy**

**Prerequisites** (tick box where appropriate)

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

**and**

Individual has a history of severe delayed beta-lactam allergy

HOSPITAL

I confirm that the above details are correct:

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