

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: .....

**Letemovir**

**INITIATION – CMV prophylaxis post HSCT**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- Patient has undergone an allogeneic haematopoietic stem cell transplant
- and  The patient has confirmed presence of cytomegalovirus-specific antibodies
- and  Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
- and  Maximum treatment duration of 100 days post-transplant

**CONTINUATION – CMV prophylaxis second or subsequent HSCT**

Re-assessment required after 4 months

**Prerequisites** (tick boxes where appropriate)

- Patient has undergone an allogeneic haematopoietic stem cell transplant
- and  The patient has confirmed presence of cytomegalovirus-specific antibodies
- and  Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
- and  Maximum treatment duration of 100 days post-transplant

**INITIATION – CMV prophylaxis in severe immunosuppression\***

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and  Patient has severe immunosuppression requiring prophylaxis of CMV
- and  Patient is contraindicated to all other funded CMV active oral antiviral agents
- or  Patients CMV is resistant to all other funded CMV active oral antiviral agents

**CONTINUATION – CMV prophylaxis in severe immunosuppression\***

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- Prescribed by, or recommended by a clinical microbiologist or infectious disease specialist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.
- and  Patient has severe immunosuppression requiring prophylaxis of CMV
- and  Patient is contraindicated to all other funded CMV active oral antiviral agents
- or  Patients CMV is resistant to all other funded CMV active oral antiviral agents

Note: Indications marked with \* are unapproved indications.

I confirm that the above details are correct:

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