

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:

Oseltamivir

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ Only for hospitalised patient with known or suspected influenza
- or
- ☐ For prophylaxis of influenza in hospitalised patients as part of a Health NZ Hospital approved infections control plan

I confirm that the above details are correct:

Signed: Date: