

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:

Letermovir

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: