

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Voriconazole

Initial application — invasive fungal infection

Applications only from a haematologist, infectious disease specialist or clinical microbiologist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient is immunocompromised
and	
<input type="checkbox"/>	Applicant is part of a multidisciplinary team including an infectious disease specialist
and	
<input type="checkbox"/>	Patient has proven or probable invasive aspergillus infection
or	
<input type="checkbox"/>	Patient has possible invasive aspergillus infection
or	
<input type="checkbox"/>	Patient has fluconazole resistant candidiasis
or	
<input type="checkbox"/>	Patient has mould strain such as <i>Fusarium</i> spp. and <i>Scedosporium</i> spp

Renewal — invasive fungal infection

Current approval Number (if known):.....

Applications only from a haematologist, infectious disease specialist or clinical microbiologist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	Patient is immunocompromised
and	
<input type="checkbox"/>	Applicant is part of a multidisciplinary team including an infectious disease specialist
and	
<input type="checkbox"/>	Patient continues to require treatment for proven or probable invasive aspergillus infection
or	
<input type="checkbox"/>	Patient continues to require treatment for possible invasive aspergillus infection
or	
<input type="checkbox"/>	Patient has fluconazole resistant candidiasis
or	
<input type="checkbox"/>	Patient has mould strain such as <i>Fusarium</i> spp. and <i>Scedosporium</i> spp

Initial application — Invasive fungal infection prophylaxis

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient is at risk of invasive fungal infection
and	
<input type="checkbox"/>	Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
or	
<input type="checkbox"/>	Prescribing voriconazole 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 the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Voriconazole - *continued*

Renewal — Invasive fungal infection prophylaxis

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/>	The patient is at risk of invasive fungal infection
and	
<input type="checkbox"/>	Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
or	
<input type="checkbox"/>	Prescribing voriconazole 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 the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz