

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)

- ☐ Patient is immunocompromised
- and
- ☐ Applicant is part of a multidisciplinary team including an infectious disease specialist
- and
- ☐ Patient has proven or probable invasive aspergillus infection
- or
- ☐ Patient has possible invasive aspergillus infection
- or
- ☐ Patient has fluconazole resistant candidiasis
- or
- ☐ Patient has mould strain such as *Fusarium* spp. and *Scedosporium* 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)

- ☐ Patient is immunocompromised
- and
- ☐ Applicant is part of a multidisciplinary team including an infectious disease specialist
- and
- ☐ Patient continues to require treatment for proven or probable invasive aspergillus infection
- or
- ☐ Patient continues to require treatment for possible invasive aspergillus infection
- or
- ☐ Patient has fluconazole resistant candidiasis
- or
- ☐ Patient has mould strain such as *Fusarium* spp. and *Scedosporium* spp

Initial application — Invasive fungal infection prophylaxis

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

Prerequisites(tick boxes where appropriate)

- ☐ The patient is at risk of invasive fungal infection
- and
- ☐ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
- or
- ☐ 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

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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)

- ☐ The patient is at risk of invasive fungal infection
- and
- ☐ Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
- or
- ☐ 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)

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