

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

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