

**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](mailto:customerservice@health.govt.nz)

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.....	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
<b>and</b>
<input type="checkbox"/> Voriconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist
<b>or</b>
<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)

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