

Antifungal Therapy Request

Completion of this form, by all prescribers (including Infectious Diseases) is required before subsequent antifungal doses will be supplied by Pharmacy. See back of form for websites for antifungal therapy algorithms and dosages.

Request Date (yyyy-Mon-dd) _____

Requested Antifungal Agent

- | | |
|--|---|
| <input type="checkbox"/> VORIconazole (check one) | <input type="checkbox"/> POSAconazole PO |
| <input type="checkbox"/> IV <input type="checkbox"/> PO | <input type="checkbox"/> MICAFungin IV |
| <input type="checkbox"/> Lipid Amphotericin B product (check one) | <input type="checkbox"/> CASPOfungin IV |
| <input type="checkbox"/> ABELCET <input type="checkbox"/> AMBISOME | <input type="checkbox"/> Other new antifungal agent _____ |

Indication

Invasive Aspergillosis

- Invasive Aspergillosis (VORIconazole) (see back of form)
or Prophylaxis of invasive fungal infections (IFI) in lung transplant patients (VORIconazole)

Candidemia/Fungemia (see back of form)

- Empiric therapy of fungemia not speciated* (micafungin preferred)
or Empiric therapy of invasive candidiasis/candidemia* (micafungin preferred)

AND (check at least one)

- Patient has received azole antifungals within previous 3 months
 Patient has moderate to severe illness Patient is intolerant of fluconazole

or Definitive therapy of invasive candidiasis/candidemia (micafungin preferred)

AND (check at least one)

- The *Candida* isolate is less susceptible to fluCONazole (current guideline is MIC greater than 8)**
Species _____ FluCONazole MIC _____ mcg/mL
- Patient has received azole antifungals within previous 3 months
 Patient is refractory to 5 days or more of fluCONazole with no clinical improvement or persistently positive cultures
 Patient is intolerant of fluconazole

* If antifungal is being used for empiric therapy, reassess therapy once susceptibilities are known.

** Switch to fluconazole if susceptible (MIC less than or equal to 8) and patient does not meet either of next two criteria.

Empiric Therapy of Febrile Neutropenia (see back of form)

- Empiric therapy of febrile neutropenia

AND Patient is intolerant of amphotericin B (check at least one)

- Creatinine has doubled from baseline **and**, in adults, is greater than or equal to 150 micromoles/L, while receiving amphotericin B
- Pre-existing renal dysfunction with a current calculated or measured creatinine clearance less than or equal to 40 mL/minute, or on dialysis
- Concomitant therapy with one or more of the following nephrotoxins: aminoglycoside, cycloSPORINE, tacrolimus, CISplatin, foscarnet, pentamidine, tenofovir
- Allergy to amphotericin B Severe documented infusion reaction to amphotericin B

Prophylaxis of Invasive Fungal Infection (IFI)

- Prophylaxis of IFI in high risk severely neutropenic (ANC less than/equal to $0.5 \times 10^9/L$) patients, i.e. AML undergoing induction or salvage chemotherapy (POSAconazole)

Other (specify) _____

Requesting Prescriber (print name) _____ Signature _____ Service _____

Upon completion, scan into Pyxis or send yellow copy to Pharmacy *immediately*.

Antifungal Therapy Request

Antifungal Therapy Algorithms and Dosages

1. Invasive Aspergillosis

See http://www.intranet2.capitalhealth.ca/pharmacy/Docs-PatientCare/treatment_of_invasive_aspergillosis_pswebsite_current.pdf

2. Invasive Candidiasis/Candidemia

See http://www.intranet2.capitalhealth.ca/pharmacy/Docs-patientCare/empiric_therapy_candidemia_flowcharts_pswebsite_current.pdf

3. Empiric Therapy of Febrile Neutropenia

See http://www.intranet2.capitalhealth.ca/pharmacy/Docs-PatientCare/fn_antifungal_tx_algorithm_pswebsite_current.pdf

Sample