HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

PRESCRIBER

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Varicella zoster vaccine [shingles vaccine]

INITIATION – people aged 65 years (Zostavax)
Re-assessment required after 1 dose
Prerequisites (tick box where appropriate)

○ One dose for all people aged 65 years

INITIATION – people aged 65 years (Shingrix)
Re-assessment required after 2 doses
Prerequisites (tick box where appropriate)

○ Two doses for all people aged 65 years

I confirm that the above details are correct:

Signed: ..... Date: .....