

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

PATIENT:

Name:

Name:

Ward:

NHI:

Hepatitis B recombinant vaccine

INITIATION

Prerequisites (tick boxes where appropriate)

- For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers
- or For children born to mothers who are hepatitis B surface antigen (HBsAg) positive
- or For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination
- or For HIV positive patients
- or For hepatitis C positive patients
- or For patients following non-consensual sexual intercourse
- or For patients prior to planned immunosuppression for greater than 28 days
- or For patients following immunosuppression
- or For solid organ transplant patients
- or For post-haematopoietic stem cell transplant (HSCT) patients
- or Following needle stick injury

I confirm that the above details are correct:

Signed: Date: