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: .....

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 following immunosuppression

or

- ○ For solid organ transplant patients

or

- ○ For post-haematopoietic stem cell transplant (HSCT) patients

or

- ○ Following needle stick injury

or

- ○ For dialysis patients

or

- ○ For liver or kidney transplant patients

I confirm that the above details are correct:

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