Form RS1916 April 2024

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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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:
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	