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:			
Pneumococcal (PCV13) conjugate vaccine				
INITIATION – Primary course for previously unvaccinal Re-assessment required after 3 doses Prerequisites (tick box where appropriate)	ted children aged under 5 years			
A primary course of three doses for previously ur	nvaccinated children up to the age of 59 months inclusive			
INITIATION – High risk individuals who have received Re-assessment required after 2 doses Prerequisites (tick box where appropriate) Two doses are funded for high risk individuals (over primary course of PCV10	PCV10 ver the age of 12 months and under 18 years) who have previously received two doses of the			
INITIATION – High risk children aged under 5 years Re-assessment required after 4 doses Prerequisites (tick boxes where appropriate)				
O Up to an additional four doses (as appropri	iate) are funded for the (re)immunisation of high-risk children aged under 5 years			
	adiation therapy, vaccinate when there is expected to be a sufficient immune response			
O Primary immune deficiencies	or O Primary immune deficiencies or O HIV infection			
O HIV infection				
O Renal failure, or nephrotic syndrome				
O Are immune-suppressed following or	rgan transplantation (including haematopoietic stem cell transplant)			
O Cochlear implants or intracranial shu	ints			
Or Cerebrospinal fluid leaks				
	more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg eigh more than 10 kg on a total daily dosage of 20 mg or greater			
	g asthma treated with high-dose corticosteroid therapy)			
O Pre term infants, born before 28 wee	ks gestation			
O Cardiac disease, with cyanosis or fai	lure			
O Diabetes				
O Down syndrome				
O Who are pre-or post-splenectomy, or	with functional asplenia			

I confirm that the above details are correct:	
Signed:	Date:

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:		
Pneumococcal (PCV13) conjugate vaccine - continued			
INITIATION – High risk individuals 5 years and over Re-assessment required after 4 doses			
Prerequisites (tick box where appropriate)			
O Up to an additional four doses (as appropriate) are funded for the (re-)immunisation of individuals 5 years and over with HIV, pre or post haematopoietic stem cell transplantation, or chemotherapy; pre- or post splenectomy; functional asplenia, pre- or post- solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, intracranial shunts, cerebrospinal fluid leaks or primary immunodeficiency			
INITIATION – Testing for primary immunodeficiency diseases			
Prerequisites (tick box where appropriate)			
O For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician			
Note: Please refer to the Immunisation Handbook for the appropriate schedu	le for catch up programmes		

I confirm that the above details are correct:

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