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:
Meningococcal B multicomponent vaccine	
INITIATION – Primary immunisation for children up to 59 months of age in Re-assessment required after 3 doses  Prerequisites (tick box where appropriate)  A primary course of up to three doses (dependent on age at first dose inclusive	
INITIATION – High-risk individuals 5 years of age or over	
Prerequisites (tick boxes where appropriate)	
O Person is aged at least 5 years	
O Up to two doses and a booster every five years for patie or	ents with functional or anatomic asplenia, HIV, complement deficiency cost-solid organ transplant uses of any group ningococcal disease of any group
INITIATION – Person is aged between 13 and 25 years (inclusive) Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)	
Person is aged between 13 and 25 years (inclusive)	
Note: *Immunosuppression due to corticosteroid or other immunosuppress greater than 28 days.	sive therapy must be for a period of

I confirm that the above details are correct:

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