HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....

COVID-19 vaccine

INITIATION – initial dose

Prerequisites (tick boxes where appropriate)

- ○ One dose for previously unvaccinated children aged 5-11 years old

or

- ○ Up to three doses for immunocompromised children aged 5-11 years old

CONTINUATION – additional dose

Prerequisites (tick boxes where appropriate)

- ○ One additional dose with the most current variant-matched vaccine every 6 months for highly immunocompromised children aged 5 to 11 years old

or

- ○ One additional dose with the most current variant-matched vaccine up to every 12 months for children aged 5 to 11 years old at high-risk of severe illness

I confirm that the above details are correct:

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