

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: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)**

**INITIATION – All children under 59 months**

**Prerequisites** (tick box where appropriate)

- ☐ All children under 59 months inclusive

**INITIATION – People over 65**

**Prerequisites** (tick box where appropriate)

- ☐ The patient is 65 years of age or over

**INITIATION – cardiovascular disease**

**Prerequisites** (tick boxes where appropriate)

- ☐ Ischaemic heart disease  
or  
☐ Congestive heart failure  
or  
☐ Rheumatic heart disease  
or  
☐ Congenital heart disease  
or  
☐ Cerebro-vascular disease

Note: hypertension and/or dyslipidaemia without evidence of end-organ disease is excluded from funding.

**INITIATION – chronic respiratory disease**

**Prerequisites** (tick boxes where appropriate)

- ☐ Asthma, if on a regular preventative therapy  
or  
☐ Other chronic respiratory disease with impaired lung function

Note: asthma not requiring regular preventative therapy is excluded from funding.

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued**

**INITIATION – Other conditions**

**Prerequisites** (tick boxes where appropriate)

- ☐ Diabetes
- or ☐ Chronic renal disease
- or ☐ Any cancer, excluding basal and squamous skin cancers if not invasive
- or ☐ Autoimmune disease
- or ☐ Immune suppression or immune deficiency
- or ☐ HIV
- or ☐ Transplant recipient
- or ☐ Neuromuscular and CNS diseases/ disorders
- or ☐ Haemoglobinopathies
- or ☐ Is a child on long term aspirin
- or ☐ Has a cochlear implant
- or ☐ Errors of metabolism at risk of major metabolic decompensation
- or ☐ Pre and post splenectomy
- or ☐ Down syndrome
- or ☐ Is pregnant

- or ☐ Patients in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Public Hospital

**INITIATION – Serious mental health conditions or addiction**

**Prerequisites** (tick boxes where appropriate)

- ☐ Schizophrenia
- or ☐ Major depressive disorder
- or ☐ Bipolar disorder
- or ☐ Schizoaffective disorder
- or ☐ Person is currently accessing secondary or tertiary mental health and addiction services

I confirm that the above details are correct:

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