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:		PATIENT:	
		Name:	
rd:		NHI:	
eumoco	ccal (PPV23) polysaccharide vaccine		
e-assessme	- High risk patients ent required after 3 doses s (tick box where appropriate)		
aspl		ransplant, or chemotherapy; pre- or post-splenectomy; or with functional ement deficiency (acquired or inherited), cochlear implants, or primary	
	High risk children		
	ent required after 2 doses s (tick boxes where appropriate)		
and	Patient is a child under 18 years for (re-)immunisation		
or		vaccinate when there is expected to be a sufficient immune response	
O	O With renal failure, or nephrotic syndrome		
O	O Who are immune-suppressed following organ transpla	antation (including haematopoietic stem cell transplant)	
O	With cochlear implants or intracranial shunts		
	O With cerebrospinal fluid leaks		
O	O Receiving corticosteroid therapy for more than two we per day or greater, or children who weigh more than 1	eeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg 0 kg on a total daily dosage of 20 mg or greater	
O	O With chronic pulmonary disease (including asthma tre	eated with high-dose corticosteroid therapy)	
O	O Pre term infants, born before 28 weeks gestation		
O	O With cardiac disease, with cyanosis or failure		
O	O With diabetes		
O	O With Down syndrome		
O	O Who are pre-or post-splenectomy, or with functional a	splenia	
	- Testing for primary immunodeficiency diseases s (tick box where appropriate)		
O For	use in testing for primary immunodeficiency diseases, on the	recommendation of an internal medicine physician or paediatrician	

I confirm that the above details are correct:

Signed: Date: