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: .....

Varicella vaccine [Chickenpox vaccine]

INITIATION – primary vaccinations
Re-assessment required after 1 dose
Prerequisites (tick boxes where appropriate)

- ○ Any infant born on or after 1 April 2016

or

- ○ For previously unvaccinated children turning 11 years old on or after 1 July 2017, who have not previously had a varicella infection (chickenpox)

INITIATION – other conditions
Re-assessment required after 2 doses
Prerequisites (tick boxes where appropriate)

for non-immune patients:

- ○ With chronic liver disease who may in future be candidates for transplantation

or

- ○ With deteriorating renal function before transplantation

or

- ○ Prior to solid organ transplant

or

- ○ Prior to any elective immunosuppression*

or

- ○ For post exposure prophylaxis who are immune competent inpatients

or

- ○ For patients at least 2 years after bone marrow transplantation, on advice of their specialist

or

- ○ For patients at least 6 months after completion of chemotherapy, on advice of their specialist

or

- ○ For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist

or

- ○ For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella

or

- ○ For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella

or

- ○ For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella

Note: * immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days

I confirm that the above details are correct:

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