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			PATIENT:
Name:			Name:
Ward:			NHI:
Varicella vaccine [Chickenpox vaccine]			
Re-asses Prerequis	INITIATION – primary vaccinations Re-assessment required after 1 dose Prerequisites (tick boxes where appropriate) O Any infant born on or after 1 April 2016		
or	0	For previously unvaccinated children turning 11 years old on or (chickenpox)	after 1 July 2017, who have not previously had a varicella infection
INITIATION – other conditions Re-assessment required after 2 doses Prerequisites (tick boxes where appropriate)			
	or or or or	 With deteriorating renal function before transplantation Prior to solid organ transplant Prior to any elective immunosuppression* 	
or or or or or		For patients at least 2 years after bone marrow transplantation, For patients at least 6 months after completion of chemotherapy For HIV positive patients non immune to varicella with mild or m For patients with inborn errors of metabolism at risk of major me For household contacts of paediatric patients who are immunoc where the household contact has no clinical history of varicella For household contacts of adult patients who have no clinical hi undergoing a procedure leading to immune compromise where	y, on advice of their specialist noderate immunosuppression on advice of HIV specialist etabolic decompensation, with no clinical history of varicella compromised, or undergoing a procedure leading to immune compromise istory of varicella and who are severely immunocompromised or
Note: * immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of			

I confirm that the above details are correct:

Signed: Date: