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:
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]	
INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate) Children aged 14 years and under	
INITIATION – other conditions Prerequisites (tick boxes where appropriate)	
O Up to 3 doses for people aged 15 to 26 years inclusive O People aged 9 to 26 years inclusive	
and Up to 3 doses for confirmed HIV infection or Up to 3 doses people with a transplant (including or Up to 4 doses for Post chemotherapy	g stem cell)
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)	
O Maximum of two doses for children aged 14 years and O Maximum of three doses for people aged 15 years and	
and The person has recurrent respiratory papillomatosis and The person has not previously had an HPV vaccine	

I confirm that the above details are correct:

Signed: Date: