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: .........................................................................................................

## Pneumococcal (PPV23) polysaccharide vaccine

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**INITIATION – High risk patients**
Re-assessment required after 3 doses
**Prerequisites** (tick box where appropriate)

○ For patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency

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**INITIATION – High risk children**
Re-assessment required after 2 doses
**Prerequisites** (tick boxes where appropriate)

○ Patient is a child under 18 years for (re-)immunisation

**and**

○ On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response

**or**

○ With primary immune deficiencies

**or**

○ With HIV infection

**or**

○ With renal failure, or nephrotic syndrome

**or**

○ Who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant)

**or**

○ With cochlear implants or intracranial shunts

**or**

○ With cerebrospinal fluid leaks

**or**

○ Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater

**or**

○ With chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy)

**or**

○ Pre term infants, born before 28 weeks gestation

**or**

○ With cardiac disease, with cyanosis or failure

**or**

○ With diabetes

**or**

○ With Down syndrome

**or**

○ Who are pre-or post-splenectomy, or with functional asplenia

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**INITIATION – Testing for primary immunodeficiency diseases**
**Prerequisites** (tick box where appropriate)

○ For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

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I confirm that the above details are correct:

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