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 or		
People aged 9 to 26 years inclusive		
O Up to 3 doses for confirmed HIV infection		
O Up to 3 doses people with a transplant (includin	g stem cell)	
O Up to 4 doses for Post chemotherapy		
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)		
O Maximum of two doses for children aged 14 years and	l under	
O Maximum of three doses for people aged 15 years an	d over	
The person has recurrent respiratory papillomatosis		
The person has not previously had an HPV vaccine		

I confirm that the above details are correct:

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