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.

PRESCRI	BER	PATIENT:	
Name:		Name:	
Ward:		NHI:	
COVID-1	19 vaccine		
	DN – initial dose sites (tick boxes where appropriate)		
or or or	One dose for previously unvaccinated people aged 12-15 year Up to three doses for immunocompromised people aged 12-19 Up to two doses for previously unvaccinated people 16-29 year Up to four doses for people aged 16-29 at high risk of severe if One dose for previously unvaccinated people aged 30 and old	5 years old rs old Ilness	
INITIATION – additional dose Prerequisites (tick box where appropriate)			
0	One additional dose every 6 months for people aged 30 years and o	ver, additional dose is given at least 6 months after last dose	
Prerequi	JATION – additional dose sites (tick box where appropriate) One additional dose every 6 months for people aged 30 years and o	ver, additional dose is given at least 6 months after last dose	

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Signed.	Date:	
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