

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**

**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

**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

**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

I confirm that the above details are correct:

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