

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: .....

**COVID-19 vaccine**

**INITIATION – initial dose**

**Prerequisites** (tick boxes where appropriate)

- ☐ One dose for previously unvaccinated people aged 12-15 years old  
or  
☐ Up to three doses for immunocompromised people aged 12-15 years old  
or  
☐ Up to two doses for previously unvaccinated people 16-29 years old  
or  
☐ Up to four doses for people aged 16-29 at high risk of severe illness  
or  
☐ One dose for previously unvaccinated people aged 30 and older

**INITIATION – additional dose**

**Prerequisites** (tick box where appropriate)

- ☐ One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

**CONTINUATION – additional dose**

**Prerequisites** (tick box where appropriate)

- ☐ One additional dose every 6 months for people aged 30 years and over, additional dose is given at least 6 months after last dose

I confirm that the above details are correct:

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