

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: .....

**Meningococcal (A, C, Y and W-135) conjugate vaccine**

**INITIATION – Children under 12 months of age**

**Prerequisites** (tick boxes where appropriate)

- ☐ A maximum of three doses (dependant on age at first dose) for patients pre- and post- splenectomy and for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited), or pre- or post- solid organ transplant
- or
- ☐ A maximum of three doses (dependant on age at first dose) for close contacts of meningococcal cases of any group
- or
- ☐ A maximum of three doses (dependant on age at first dose) for child who has previously had meningococcal disease of any group
- or
- ☐ A maximum of three doses (dependant on age at first dose) for bone marrow transplant patients
- or
- ☐ A maximum of three doses (dependant on age at first dose) for child pre- and post-immunosuppression\*

Note: infants from 6 weeks to less than 6 months of age require a 2+1 schedule, infants from 6 months to less than 12 months of age require a 1+1 schedule. Refer to the Immunisation Handbook for recommended booster schedules with meningococcal ACWY vaccine.

\*Immunosuppression due to steroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:

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