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:				e:		
Ward:			NHI:			
Hepat	itis	В	recombinant vaccine			
INITIA		-				
Prerec	luis	ites	s (tick boxes where appropriate)			
	(\circ	For household or sexual contacts of known acute hepatitis B patient	s or hepatitis B carriers		
or	or (\circ	For children born to mothers who are hepatitis B surface antigen (HBsAg) positive For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination			
	or (0				
'	or (0	For HIV positive patients			
OI	or (\circ	For hepatitis C positive patients			
	or (\bigcirc	For patients following non-consensual sexual intercourse			
	or	\bigcirc				
or	or (\bigcirc	For patients prior to planned immunosuppression for greater than 28	days		
	or (\bigcirc	For patients following immunosuppression			
	(\circ	For solid organ transplant patients			
'	or (\circ	For post-haematopoietic stem cell transplant (HSCT) patients			
	or (0	Following needle stick injury			

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