

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:

Hepatitis B recombinant vaccine

INITIATION

Prerequisites (tick boxes where appropriate)

- ☐ For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers
- or ☐ For children born to mothers who are hepatitis B surface antigen (HBsAg) positive
- or ☐ 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 ☐ For HIV positive patients
- or ☐ For hepatitis C positive patients
- or ☐ For patients following non-consensual sexual intercourse
- or ☐ For patients prior to planned immunosuppression for greater than 28 days
- or ☐ For patients following immunosuppression
- or ☐ For solid organ transplant patients
- or ☐ For post-haematopoietic stem cell transplant (HSCT) patients
- or ☐ Following needle stick injury
- or ☐ For dialysis patients
- or ☐ For liver or kidney transplant patients

I confirm that the above details are correct:

Signed: Date: