HOSPITAL MEDICINES LIST
RESTRICTIONS CHECKLIST

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: .....