

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: .....

**Varicella vaccine [Chickenpox vaccine]**

**INITIATION – primary vaccinations**

Re-assessment required after 1 dose

**Prerequisites** (tick boxes where appropriate)

- ☐ Any infant born on or after 1 April 2016
- or
- ☐ For previously unvaccinated children turning 11 years old on or after 1 July 2017, who have not previously had a varicella infection (chickenpox)

**INITIATION – other conditions**

Re-assessment required after 2 doses

**Prerequisites** (tick boxes where appropriate)

- for non-immune patients:**
- ☐ With chronic liver disease who may in future be candidates for transplantation
- or
- ☐ With deteriorating renal function before transplantation
- or
- ☐ Prior to solid organ transplant
- or
- ☐ Prior to any elective immunosuppression\*
- or
- ☐ For post exposure prophylaxis who are immune competent inpatients
- or
- ☐ For patients at least 2 years after bone marrow transplantation, on advice of their specialist
- or
- ☐ For patients at least 6 months after completion of chemotherapy, on advice of their specialist
- or
- ☐ For HIV positive patients non immune to varicella with mild or moderate immunosuppression on advice of HIV specialist
- or
- ☐ For patients with inborn errors of metabolism at risk of major metabolic decompensation, with no clinical history of varicella
- or
- ☐ For household contacts of paediatric patients who are immunocompromised, or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella
- or
- ☐ For household contacts of adult patients who have no clinical history of varicella and who are severely immunocompromised or undergoing a procedure leading to immune compromise where the household contact has no clinical history of varicella

Note: \* immunosuppression due to steroid or other immunosuppressive therapy must be for a treatment period of greater than 28 days

I confirm that the above details are correct:

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