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:	Name:
Ward:	NHI:
Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]	
INITIATION – Children aged 14 years and under Re-assessment required after 2 doses Prerequisites (tick box where appropriate)	
O Children aged 14 years and under	
INITIATION – other conditions Prerequisites (tick boxes where appropriate)	
O Up to 3 doses for people aged 15 to 26 years inclusive	
People aged 9 to 26 years inclusive	
O Up to 3 doses for confirmed HIV infection	
O Up to 3 doses people with a transplant (inc	cluding stem cell)
O Up to 4 doses for Post chemotherapy	
INITIATION – Recurrent Respiratory Papillomatosis Prerequisites (tick boxes where appropriate)	
O Maximum of two doses for children aged 14 year	rs and under
O Maximum of three doses for people aged 15 year	rs and over
The person has recurrent respiratory papillomatosis	
O The person has not previously had an HPV vaccine	

I confirm that the above details are correct:

Signed: Date: