

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 zoster vaccine [shingles vaccine]**

**INITIATION – people aged 18 years and over (Shingrix)**

Re-assessment required after 2 doses

**Prerequisites** (tick boxes where appropriate)

- ☐ Pre- and post-haematopoietic stem cell transplant or cellular therapy  
or  
☐ Pre- or post-solid organ transplant  
or  
☐ Haematological malignancies  
or  
☐ People living with poorly controlled HIV infection  
or  
☐ Planned or receiving disease modifying anti-rheumatic drugs (DMARDs – targeted synthetic, biologic, or conventional synthetic) for polymyalgia rheumatica, systemic lupus erythematosus or rheumatoid arthritis  
or  
☐ End stage kidney disease (CKD 4 or 5);  
or  
☐ Primary immunodeficiency

I confirm that the above details are correct:

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