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



I confirm that the above details are correct:

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