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	PATIENT:
Name:	Name:
Ward:	NHI:
Hepatitis B recombinant vaccine	
INITIATION Prerequisites (tick boxes where appropriate)	
additional vaccination or require a primary course of vaccination	gen (HBsAg) positive no are considered not to have achieved a positive serology and require
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 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 or For dialysis patients	
O For liver or kidney transplant patients	

I confirm that the above details are correct:

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