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

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: .....