

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: .....

**Palivizumab**

**INITIATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

☐ Palivizumab to be administered during the annual RSV season

and

☐ Infant was born in the last 12 months

and

☐ Infant was born at less than 32 weeks zero days' gestation

or

☐ Child was born in the last 24 months

and

☐ Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community

or

☐ Child has haemodynamically significant heart disease

and

☐ Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)

or

☐ Child has unoperated or surgically palliated complex congenital heart disease

or

☐ Child has severe pulmonary hypertension (see Note C)

or

☐ Child has moderate or severe left ventricular (LV) failure (see Note D)

or

☐ Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant

or

☐ Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

I confirm that the above details are correct:

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

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**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

**Palivizumab** - continued

**CONTINUATION**

Re-assessment required after 6 months

**Prerequisites** (tick boxes where appropriate)

- ☐ Palivizumab to be administered during the annual RSV season
- and
- ☐ Child was born in the last 24 months
- and
- ☐ Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community
- or
- ☐ Child has haemodynamically significant heart disease
- and
- ☐ Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)
- or
- ☐ Child has unoperated or surgically palliated complex congenital heart disease
- or
- ☐ Child has severe pulmonary hypertension (see Note C)
- or
- ☐ Child has moderate or severe left ventricular (LV) failure (see Note D)
- or
- ☐ Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant
- or
- ☐ Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

**Note:**

- a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home
- b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months
- c) Mean pulmonary artery pressure more than 25 mmHg
- d) LV Ejection Fraction less than 40%
- e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

I confirm that the above details are correct:

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