

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: Name:

Ward: NHI:

Pneumococcal (PPV23) polysaccharide vaccine

INITIATION – High risk patients

Re-assessment required after 3 doses

Prerequisites (tick box where appropriate)

For patients with HIV, for patients post haematopoietic stem cell transplant, or chemotherapy; pre- or post-splenectomy; or with functional asplenia, pre- or post-solid organ transplant, renal dialysis, complement deficiency (acquired or inherited), cochlear implants, or primary immunodeficiency

INITIATION – High risk children

Re-assessment required after 2 doses

Prerequisites (tick boxes where appropriate)

Patient is a child under 18 years for (re-)immunisation
and

On immunosuppressive therapy or radiation therapy, vaccinate when there is expected to be a sufficient immune response
or
 With primary immune deficiencies
or
 With HIV infection
or
 With renal failure, or nephrotic syndrome
or
 Who are immune-suppressed following organ transplantation (including haematopoietic stem cell transplant)
or
 With cochlear implants or intracranial shunts
or
 With cerebrospinal fluid leaks
or
 Receiving corticosteroid therapy for more than two weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater
or
 With chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy)
or
 Pre term infants, born before 28 weeks gestation
or
 With cardiac disease, with cyanosis or failure
or
 With diabetes
or
 With Down syndrome
or
 Who are pre- or post-splenectomy, or with functional asplenia

INITIATION – Testing for primary immunodeficiency diseases

Prerequisites (tick box where appropriate)

For use in testing for primary immunodeficiency diseases, on the recommendation of an internal medicine physician or paediatrician

I confirm that the above details are correct:

Signed: Date: