

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: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)**

**INITIATION – People over 65**

Prerequisites (tick box where appropriate)

The patient is 65 years of age or over

**INITIATION – cardiovascular disease**

Prerequisites (tick boxes where appropriate)

Ischaemic heart disease  
or  
 Congestive heart failure  
or  
 Rheumatic heart disease  
or  
 Congenital heart disease  
or  
 Cerebro-vascular disease

Note: hypertension and/or dyslipidaemia without evidence of end-organ disease is excluded from funding.

**INITIATION – chronic respiratory disease**

Prerequisites (tick boxes where appropriate)

Asthma, if on a regular preventative therapy  
or  
 Other chronic respiratory disease with impaired lung function

Note: asthma not requiring regular preventative therapy is excluded from funding.

I confirm that the above details are correct:

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

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**PREScriBER**

Name: ..... Name: .....

Ward: ..... NHI: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)** - *continued*

**INITIATION – Other conditions**

**Prerequisites** (tick boxes where appropriate)

- Diabetes
- or  Chronic renal disease
- or  Any cancer, excluding basal and squamous skin cancers if not invasive
- or  Autoimmune disease
- or  Immune suppression or immune deficiency
- or  HIV
- or  Transplant recipient
- or  Neuromuscular and CNS diseases/ disorders
- or  Haemoglobinopathies
- or  Is a child on long term aspirin
- or  Has a cochlear implant
- or  Errors of metabolism at risk of major metabolic decompensation
- or  Pre and post splenectomy
- or  Down syndrome
- or  Is pregnant
- or  Is a child 4 years of age or under (inclusive) who has been hospitalised for respiratory illness or has a history of significant respiratory illness
- or  Patients in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a Public Hospital

**INITIATION – Serious mental health conditions or addiction**

**Prerequisites** (tick boxes where appropriate)

- Schizophrenia
- or  Major depressive disorder
- or  Bipolar disorder
- or  Schizoaffective disorder
- or  Person is currently accessing secondary or tertiary mental health and addiction services

I confirm that the above details are correct:

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