

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:

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: