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: .....

Haemophilus influenzae type B vaccine

INITIATION
Re-assessment required after 1 dose
Prerequisites (tick boxes where appropriate)

- ○ For primary vaccination in children

or

- ○ An additional dose (as appropriate) is funded for (re-)immunisation for patients post haematopoietic stem cell transplantation, or chemotherapy; functional asplenic; pre or post splenectomy; pre- or post solid organ transplant, pre- or post cochlear implants, renal dialysis and other severely immunosuppressive regimens

or

- ○ 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: .....