

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: .....

**Meningococcal B multicomponent vaccine**

**INITIATION – Primary immunisation for children up to 59 months of age inclusive**

Re-assessment required after 3 doses

**Prerequisites** (tick box where appropriate)

- A primary course of up to three doses (dependent on age at first dose) for previously unvaccinated children up to the age of 59 months inclusive

**INITIATION – High-risk individuals 5 years of age or over**

**Prerequisites** (tick boxes where appropriate)

- Person is aged at least 5 years  
and
- Up to two doses and a booster every five years for patients pre- and post-splenectomy  
or  
 Up to two doses and a booster every five years for patients with functional or anatomic asplenia, HIV, complement deficiency (acquired or inherited)  
or  
 Up to two doses and a booster every five years pre- or post-solid organ transplant  
or  
 Up to two doses for close contacts of meningococcal cases of any group  
or  
 Up to two doses for person who has previously had meningococcal disease of any group  
or  
 Up to two doses for bone marrow transplant patients  
or  
 Up to two doses for person pre- and post-immunosuppression\*

**INITIATION – Person is aged between 13 and 25 years (inclusive)**

Re-assessment required after 2 doses

**Prerequisites** (tick boxes where appropriate)

- Person is aged between 13 and 25 years (inclusive)  
and
- Two doses for individuals who are entering within the next three months, or in their first year of living in boarding school hostels, tertiary education halls of residence, military barracks, Youth Justice residences, or prisons  
or  
 Two doses for individuals who turn 13 years of age while living in boarding school hostels

Note: \*Immunosuppression due to corticosteroid or other immunosuppressive therapy must be for a period of greater than 28 days.

I confirm that the above details are correct:

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