

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**

**PATIENT:**

Name: .....

Name: .....

Ward: .....

NHI: .....

**Hepatitis B recombinant vaccine**

**INITIATION**

**Prerequisites** (tick boxes where appropriate)

- For household or sexual contacts of known acute hepatitis B patients or hepatitis B carriers
- or
- For children born to mothers who are hepatitis B surface antigen (HBsAg) positive
- or
- For children up to and under the age of 18 years inclusive who are considered not to have achieved a positive serology and require additional vaccination or require a primary course of vaccination
- or
- For HIV positive patients
- or
- For hepatitis C positive patients
- or
- For patients following non-consensual sexual intercourse
- or
- For patients prior to planned immunosuppression for greater than 28 days
- or
- For patients following immunosuppression
- or
- For solid organ transplant patients
- or
- For post-haematopoietic stem cell transplant (HSCT) patients
- or
- Following needle stick injury
- or
- For chronic kidney disease (CKD) stage 4 or 5 patients
- or
- For liver or kidney transplant patients

I confirm that the above details are correct:

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