

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: .....

**Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]**

**INITIATION – Children aged 14 years and under**

Re-assessment required after 2 doses

**Prerequisites** (tick box where appropriate)

- ☐ Children aged 14 years and under

**INITIATION – other conditions**

**Prerequisites** (tick boxes where appropriate)

- ☐ Up to 3 doses for people aged 15 to 26 years inclusive
- or
- ☐ People aged 9 to 26 years inclusive
- and
- ☐ Up to 3 doses for confirmed HIV infection
- or
- ☐ Up to 3 doses people with a transplant (including stem cell)
- or
- ☐ Up to 4 doses for Post chemotherapy

**INITIATION – Recurrent Respiratory Papillomatosis**

**Prerequisites** (tick boxes where appropriate)

- ☐ Maximum of two doses for children aged 14 years and under
- or
- ☐ Maximum of three doses for people aged 15 years and over
- and
- ☐ The person has recurrent respiratory papillomatosis
- and
- ☐ The person has not previously had an HPV vaccine

I confirm that the above details are correct:

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