

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

Prerequisites (tick boxes where appropriate)

- ☐ For primary vaccination in children
- or
- ☐ An additional dose (as appropriate) is funded for (re-)immunisation for patients post 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
- ☐ An additional 3 doses (as appropriate) funded for (re-)immunisation for people post haematopoietic stem cell transplantation
- 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: