

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:

PATIENT

Name:

Ward:

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:

Signature: Date: