

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: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine)**

**INITIATION - People over 65**

**Prerequisites** (tick box where appropriate)

The patient is 65 years of age or over

**INITIATION - cardiovascular disease for patients 3 years and over**

**Prerequisites** (tick boxes where appropriate)

Ischaemic heart disease

or

Congestive heart failure

or

Rheumatic heart disease

or

Congenital heart disease

or

Cerebro-vascular disease

Note:

hypertension and/or dyslipidaemia without evidence of end-organ disease is excluded from funding.

**INITIATION - chronic respiratory disease for patients 3 years and over**

**Prerequisites** (tick boxes where appropriate)

Asthma, if on a regular preventative therapy

or

Other chronic respiratory disease with impaired lung function

Note:

asthma not requiring regular preventative therapy is excluded from funding.

I confirm that the above details are correct:

Signature: .....

Date: .....

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**PRESCRIBER**

**PATIENT**

Name: ..... Name: .....

Ward: ..... NHI: .....

**Influenza vaccine Inj 60 mcg in 0.5 ml syringe (quadrivalent vaccine) - continued**

**INITIATION - Other conditions for patients 3 years and over**

**Prerequisites** (tick boxes where appropriate)

Diabetes

or

chronic renal disease

or

Any cancer, excluding basal and squamous skin cancers if not invasive

or

Autoimmune disease

or

Immune suppression or immune deficiency

or

HIV

or

Transplant recipient

or

Neuromuscular and CNS diseases/ disorders

or

Haemoglobinopathies

or

Is a child on long term aspirin

or

Has a cochlear implant

or

Errors of metabolism at risk of major metabolic decompensation

or

Pre and post splenectomy

or

Down syndrome

or

Is pregnant

or

Is a child aged four and under who has been hospitalised for respiratory illness or has a history of significant respiratory illness

or

Patients in a long-stay inpatient mental health care unit or who are compulsorily detained long-term in a forensic unit within a DHB hospital

I confirm that the above details are correct:

Signature: ..... Date: .....