Form RS1675
October 2019

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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: ....

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

INITIATION - cardiovascular disease for patients aged 6 months to 35 months

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 aged 6 months to 35 months

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: ....

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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: ....

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

INITIATION - Other conditions for patients aged 6 months to 35 months

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
- ◯ Child who has been hospitalised for respiratory illness or has a history of significant respiratory illness

I confirm that the above details are correct:

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