

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: .....

**Nusinersen**

**INITIATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation
- and
- Patient is 18 years of age or under
- and
- Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age
- or
- Patient is pre-symptomatic
- and
- Patient has three or less copies of SMN2

**CONTINUATION**

Re-assessment required after 12 months

**Prerequisites** (tick boxes where appropriate)

- There has been demonstrated maintenance of motor milestone function since treatment initiation
- and
- Patient does not require invasive permanent ventilation (at least 16 hours per day), in the absence of a potentially reversible cause while being treated with nusinersen
- and
- Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy

I confirm that the above details are correct:

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