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		PATIENT:
Name:		Name:
Ward:		NHI:
Galsulfase		
	nt required after 12 months s (tick boxes where appropriate)	
	scribed by, or recommended by a metabolic physician, or in according to the scriber of the scrib	ordance with a protocol or guideline that has been endorsed by the Health
and	enzyme activity assay in leukocytes or skin fibroblasts	ctosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either has a sibling who is known to have mucopolysaccharidosis VI
Prerequisites O Pres	nt required after 12 months s (tick boxes where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health
and and	adjustment of infusion rates	ent is benefiting from treatment which were not preventable by appropriate pre-medication and/or isease where the long term prognosis is unlikely to be influenced by