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: .....

Vigabatrin

INITIATION
Re-assessment required after 15 months
Prerequisites (tick boxes where appropriate)

- ○ Patient has infantile spasms
- **or**
- ○ Patient has epilepsy
- **and**
- ○ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents
- **or**
- ○ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents
- **or**
- ○ Patient has tuberous sclerosis complex
- **and**
- ○ Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)
- **or**
- ○ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

CONTINUATION
Prerequisites (tick boxes where appropriate)

- ○ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life
- **and**
- ○ Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin
- **or**
- ○ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

I confirm that the above details are correct:

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