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:	

Vigabatrin

INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)					
			D Patient has infantile spasms		
		or	O Patient has epilepsy and		
			or O Seizures are not adequately controlled with optimal treatment with other antiepilepsy age		
			O Seizures are controlled adequately but the patient has experienced unacceptable side eff treatment with other antiepilepsy agents		
and or O Patient has tuberous sclerosis complex					
O Patient is, or will be, receiving regular automated visual field testing (ideally before starting therap thereafter)		nd on a 6-monthly basis			
		or	D It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields		
CONTINUATION Prerequisites (tick boxes where appropriate)					
	O The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life and				
		or	Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basi with vigabatrin	s for duration of treatment	

O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields