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: .....

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: .....