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:		
Risdiplam				
	t required after 12 months (tick boxes where appropriate)			
and on and	Patient has genetic documentation of homozygous SMN1 geneterozygous mutation  Patient is 18 years of age or under	ne deletion, homozygous SMN1 point mutation, or compound		
or	O Patient has experienced the defined signs and symptom  O Patient is pre-symptomatic  and O Patient has three or less copies of SMN2	is of SMA type I, II or IIIa prior to three years of age		
	t required after 12 months (tick boxes where appropriate)			
and	There has been demonstrated maintenance of motor mileston  Patient does not require invasive permanent ventilation (at lea while being treated with risdiplam	e function since treatment initiation st 16 hours per day), in the absence of a potentially reversible cause		
and	Risdiplam not to be administered in combination other SMA disease modifying treatments or gene therapy			

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