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.

PRES	CRIB	ER		PATIENT:			
Name:				Name:			
Ward:				NHI:			
Idursulfase							
Re-as	NITIATION Re-assessment required after 24 weeks Prerequisites (tick boxes where appropriate) Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.						
anu	and	C	The patient has been diagnosed with Hunter Syndrome (muco	polysacchardosis II)			
		or	Diagnosis confirmed by demonstration of iduronate 2-sulcultured skin fibroblasts Detection of a disease causing mutation in the iduronate	Ifatase deficiency in white blood cells by either enzyme assay in 2-sulfatase gene			
	and	C	Patient is going to proceed with a haematopoietic stem cell transwould be bridging treatment to transplant	nsplant (HSCT) within the next 3 months and treatment with idursulfase			
	and	О О		ratory failure prior to starting Enzyme Replacement Therapy (ERT) ent to 12 weeks pre- and 12 weeks post-HSCT) at doses no greater than			

I confirm that the above details are correct:

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