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.

PRESC	RIBE	R	PATIENT:				
Name:							
Ward:			NHI:				
Laroni	das	е					
Prerequ	essm uisite Pre	s (tic	equired after 24 weeks k boxes where appropriate) ed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by the Health bital.				
and	nd _	) Th	The patient has been diagnosed with Hurler Syndrome (mucopolysacchardosis I-H)				
	c	or (	Diagnosis confirmed by demonstration of alpha-L-iduronidase deficiency in white blood cells by either enzyme assay in cultured skin fibroblasts  Detection of two disease causing mutations in the alpha-L-iduronidase gene and patient has a sibling who is known to have Hurler syndrome				
and	$\subset$		atient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with laronidase buld be bridging treatment to transplant				
	0	<b>)</b> La	atient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT) aronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 10 units/kg every week				

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Signed.	Date:	
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