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	CRIE	BER		PATIENT:				
Name	e:			Name:				
Ward	:			NHI:				
Gals	Galsulfase							
Re-a		smer	nt required after 12 months (tick boxes where appropriate)					
and		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.						
	and	0	The patient has been diagnosed with mucopolysaccharidosis	VI				
		or	enzyme activity assay in leukocytes or skin fibroblasts	tosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either has a sibling who is known to have mucopolysaccharidosis VI				
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)								
and	O 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.							
	and	0	The treatment remains appropriate for the patient and the patie	ent is benefiting from treatment				
	and	0	Patient has not had severe infusion-related adverse reactions adjustment of infusion rates	which were not preventable by appropriate pre-medication and/or				
	and	0	Patient has not developed another life threatening or severe di Enzyme Replacement Therapy (ERT)	sease where the long term prognosis is unlikely to be influenced by				
	anu	0	Patient has not developed another medical condition that migh	nt reasonably be expected to compromise a response to ERT				

I confirm that the above details are correct:

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