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:		
Nusi	nersen	ı			
Re-a		nt required after 12 months s (tick boxes where appropriate)			
	and o	Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation  Patient is 18 years of age or under			
		Patient has experienced the defined signs and symptoms  Patient is pre-symptomatic  and  Patient has three or less copies of SMN2	of SMA type I, II or IIIa prior to three years of age		
Re-a		ON nt required after 12 months s (tick boxes where appropriate)			
	and	There has been demonstrated maintenance of motor milestone  Patient does not require invasive permanent ventilation (at least while being treated with nusinersen	function since treatment initiation t 16 hours per day), in the absence of a potentially reversible cause		
	and	Nusinersen not to be administered in combination other SMA di	isease modifying treatments or gene therapy		

I confirm that the above details are correct:

C:	D-1	
Signed.	Date:	
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