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	
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
Patient has genetic documentation of homozygous SMN1 grand  Patient is 18 years of age or under and	ene deletion, homozygous SMN1 point mutation, or compound
O Patient has experienced the defined signs and symptomatic  O Patient is pre-symptomatic  and O Patient has three or less copies of SMN2	ms of SMA type I, II or IIIa prior to three years of age
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)	
There has been demonstrated maintenance of motor milesto and Patient does not require invasive permanent ventilation (at le while being treated with risdiplam  Risdiplam not to be administered in combination other SMA of	ast 16 hours per day), in the absence of a potentially reversible cause

I confirm that the above details are correct:

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