HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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:
Galsulfase		
Prerequisites	nt required after 12 months (tick boxes where appropriate)	ordance with a protocol or guideline that has been endorsed by the Health
	The patient has been diagnosed with mucopolysaccharidosis Diagnosis confirmed by demonstration of N-acetyl-galac enzyme activity assay in leukocytes or skin fibroblasts	
Prerequisites O Pres	nt required after 12 months (tick boxes where appropriate) cribed by, or recommended by a metabolic physician, or in accolospital. The treatment remains appropriate for the patient and the patient has not had severe infusion-related adverse reactions adjustment of infusion rates	which were not preventable by appropriate pre-medication and/or isease where the long term prognosis is unlikely to be influenced by

0:	D - 1 - 1	
Zigneg.	i jate:	
Oigilica.	 Duic.	