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

Name: .....

Ward: .....

PATIENT:

Name: .....

NHI: .....

Galsulfase

INITIATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ 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

- ○ The patient has been diagnosed with mucopolysaccharidosis VI

and

- ○ Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either enzyme activity assay in leukocytes or skin fibroblasts

or

- ○ Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI

CONTINUATION
Re-assessment required after 12 months
Prerequisites (tick boxes where appropriate)

- ○ 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

- ○ The treatment remains appropriate for the patient and the patient is benefiting from treatment

and

- ○ Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates

and

- ○ Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by Enzyme Replacement Therapy (ERT)

and

- ○ Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

I confirm that the above details are correct:

Signed: ..... Date: .....