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:	

Vigabatrin

INITIATION Re-assessment required after 15 months Prerequisites (tick boxes where appropriate)					
Prei		or	Patient has infantile spasms Patient has epilepsy nd O Seizures are not adequately controlled with optimal treatment with ot or O Seizures are controlled adequately but the patient has experienced u treatment with other antiepilepsy agents		
	O Patient has tuberous sclerosis complex				
	and	or	Patient is, or will be, receiving regular automated visual field testing (ideally befor thereafter) It is impractical or impossible (due to comorbid conditions) to monitor the patient		
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CONTINUATION Prerequisites (tick boxes where appropriate)					
	O The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life and				
	unu	or	Patient is receiving regular automated visual field testing (ideally every 6 months) with vigabatrin) on an ongoing basis for duration of treatment	

O It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

I confirm that the above details are correct:

Signed: Date: