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			IENT:	
Name:		Nar	ne:	
Ward:		NHI		
Galsulfase				
INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)				
(and		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		
	O Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by eigenzyme activity assay in leukocytes or skin fibroblasts O 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 Patient has not had severe infusion-related adverse reactions which adjustment of infusion rates		
	and _	Patient has not developed another life threatening or severe diseas Enzyme Replacement Therapy (ERT)	e where the long term prognosis is unlikely to be influenced by	
	0	Patient has not developed another medical condition that might rea	sonably be expected to compromise a response to ERT	