

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:

Vigabatrin

INITIATION

Re-assessment required after 15 months

Prerequisites (tick boxes where appropriate)

☐ Patient has infantile spasms

or

☐ Patient has epilepsy

and

☐ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents

or

☐ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

or

☐ Patient has tuberous sclerosis complex

and

☐ Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)

or

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

CONTINUATION

Prerequisites (tick boxes where appropriate)

☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life

and

☐ Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin

or

☐ 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: