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						
Re-a	INITIATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)					
and	O Prescribed by, or recommended by a metabolic physician, or in accordance with a protocol or guideline that has been endorsed by NZ Hospital.					
	and	The patient has been diagnosed with mucopolysaccharidosis	VI			
		enzyme activity assay in leukocytes or skin fibroblasts	tosamine-4-sulfatase (arylsulfatase B) deficiency confirmed by either has a sibling who is known to have mucopolysaccharidosis VI			
CONTINUATION Re-assessment required after 12 months Prerequisites (tick boxes where appropriate)						
and	O 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 pati	ent is benefiting from treatment			
	and	Patient has not had severe infusion-related adverse reactions adjustment of infusion rates	which were not preventable by appropriate pre-medication and/or			
	and	Patient has not developed another life threatening or severe di Enzyme Replacement Therapy (ERT)	sease where the long term prognosis is unlikely to be influenced by			
		Patient has not developed another medical condition that migh	nt reasonably be expected to compromise a response to ERT			

I confirm that the above details are correct:

Cianad.	Data.	
Signeg	 Date	