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: .....