

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: 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: