

APPLICANT (stamp or sticker acceptable) **PATIENT NHI:** **REFERRER** Reg No:

Reg No: First Names: First Names:

Name: Surname: Surname:

Address: DOB: Address:

..... Address:

.....

Fax Number: Fax Number:

Galsulfase

Initial application

Applications only from a metabolic physician. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

The patient has been diagnosed with mucopolysaccharidosis VI

and

Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency 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

Renewal

Current approval Number (if known):.....

Applications only from a metabolic physician. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

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 the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz