

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