

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

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Ursodeoxycholic Acid**

**Initial application — Alagille syndrome or progressive familial intrahepatic cholestasis**  
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  
**Prerequisites**(tick boxes where appropriate)

Patient has been diagnosed with Alagille syndrome  
or  
 Patient has progressive familial intrahepatic cholestasis

**Initial application — Chronic severe drug induced cholestatic liver injury**  
Applications from any relevant practitioner. Approvals valid for 3 months.  
**Prerequisites**(tick boxes where appropriate)

Patient has chronic severe drug induced cholestatic liver injury  
and  
 Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults  
and  
 Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay

**Initial application — Primary biliary cholangitis**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick boxes where appropriate)

Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy  
and  
 Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis)

**Initial application — Pregnancy**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick box where appropriate)

The patient diagnosed with cholestasis of pregnancy

**Initial application — Haematological Transplant**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick boxes where appropriate)

Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogenic stem cell or bone marrow transplantation  
and  
 Treatment for up to 13 weeks

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

Signed: ..... Date: .....

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: [customerservice@health.govt.nz](mailto:customerservice@health.govt.nz)

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.....	Address: .....	.....
.....	.....	.....
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**Ursodeoxycholic Acid** - *continued*

**Initial application — Total parenteral nutrition induced cholestasis**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/> Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by Total Parenteral Nutrition (TPN) <b>and</b> <input type="checkbox"/> Liver function has not improved with modifying the TPN composition
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**Renewal — Chronic severe drug induced cholestatic liver injury**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

The patient continues to benefit from treatment

**Renewal — Pregnancy/Primary biliary cholangitis**

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

**Renewal — Total parenteral nutrition induced cholestasis**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick box where appropriate)

The paediatric patient continues to require TPN and who is benefiting from treatment, defined as a sustained improvement in bilirubin levels

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

Signed: ..... Date: .....

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