

**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: .....

**Budesonide - Cap 3 mg Controlled Release**

**Initial application — Crohn's disease**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick boxes where appropriate)

Mild to moderate ileal, ileocaecal or proximal Crohn's disease  
and

Diabetes  
or  
 Cushingoid habitus  
or  
 Osteoporosis where there is significant risk of fracture  
or  
 Severe acne following treatment with conventional corticosteroid therapy  
or  
 History of severe psychiatric problems associated with corticosteroid treatment  
or  
 History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high  
or  
 Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)

**Initial application — collagenous and lymphocytic colitis (microscopic colitis)**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick box where appropriate)

Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies

**Initial application — gut Graft versus Host disease**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick box where appropriate)

Patient has a gut Graft versus Host disease following allogenic bone marrow transplantation\*  
Note: Indication marked with \* is an unapproved indication.

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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**Budesonide - Cap 3 mg Controlled Release** - continued

**Initial application — non-cirrhotic autoimmune hepatitis**

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

**Prerequisites**(tick boxes where appropriate)

Patient has autoimmune hepatitis\*

**and**

Patient does not have cirrhosis

**and**

Diabetes

**or**

Cushingoid habitus

**or**

Osteoporosis where there is significant risk of fracture

**or**

Severe acne following treatment with conventional corticosteroid therapy

**or**

History of severe psychiatric problems associated with corticosteroid treatment

**or**

History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high

**or**

Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)

**or**

Adolescents with poor linear growth (where conventional corticosteroid use may limit further growth)

Note: Indication marked with \* is an unapproved indication.

**Renewal**

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

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

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

**Renewal — non-cirrhotic autoimmune hepatitis**

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

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

**Prerequisites**(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

**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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