Form RS1723
June 2024

HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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: ....

PATIENT:

Name: ....

NHI: ....

Budesonide

INITIATION – Crohn's disease
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)

INITIATION – Collagenous and lymphocytic colitis (microscopic colitis)
Prerequisites (tick box where appropriate)

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

INITIATION – Gut Graft versus Host disease
Prerequisites (tick box where appropriate)

- ◯ Patient has gut Graft versus Host disease following allogenic bone marrow transplantation

HOSPITAL

I confirm that the above details are correct:

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

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: ....

PATIENT:

Name: ....

NHI: ....

Budesonide *- continued*

INITIATION – non-cirrhotic autoimmune hepatitis
Re-assessment required after 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: Indications marked with * are unapproved indications.

CONTINUATION – non-cirrhotic autoimmune hepatitis
Re-assessment required after 6 months
Prerequisites (tick box where appropriate)

- ◯ Treatment remains appropriate and the patient is benefitting from the treatment

I confirm that the above details are correct:

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

HOSPITAL