

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:

Ursodeoxycholic acid

INITIATION – Alagille syndrome or progressive familial intrahepatic cholestasis

Prerequisites (tick boxes where appropriate)

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

INITIATION – Chronic severe drug induced cholestatic liver injury

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

INITIATION – Primary biliary cholangitis

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)

INITIATION – Pregnancy

Prerequisites (tick box where appropriate)

- Patient diagnosed with cholestasis of pregnancy

INITIATION – Haematological transplant

Prerequisites (tick boxes where appropriate)

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

INITIATION – Total parenteral nutrition induced cholestasis

Prerequisites (tick boxes where appropriate)

- Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by TPN
and
 Liver function has not improved with modifying the TPN composition

I confirm that the above details are correct:

Signed: Date:

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PRESCRIBER

PATIENT:

Name:

Name:

Ward:

NHI:

Ursodeoxycholic acid - *continued*

INITIATION – prevention of sinusoidal obstruction syndrome

Re-assessment required after 6 months

Prerequisites (tick boxes where appropriate)

- The patient is enrolled in the Children's Oncology Group AALL1732 trial
- and**
- The patient has leukaemia/lymphoma and is receiving inotuzumab ozogamicin

HOSPITAL

I confirm that the above details are correct:

Signed: Date: