

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

I confirm that the above details are correct:

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

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**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: .....