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

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: .....