

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: ..... Name: .....

Ward: ..... 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: ..... Name: .....

Ward: ..... 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

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