

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**

**PATIENT:**

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
- 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: .....