Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1886
July 2024

APPLICANT (stamp or sticker acceptable)	**PATIENT** NHI:	**REFERRER** Reg No: ....
Reg No:	First Names:	First Names: ....
Name:	Surname:	Surname: ....
Address:	DOB:	Address: ....
....	Address:	....
....	....	....
Fax Number:	....	Fax Number: ....

Budesonide - Cap 3 mg Controlled Release

Initial application — Crohn's disease
Applications from any relevant practitioner. Approvals valid for 6 months.
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)

Initial application — collagenous and lymphocytic colitis (microscopic colitis)
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

☐ Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies

Initial application — gut Graft versus Host disease
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

☐ Patient has a gut Graft versus Host disease following allogenic bone marrow transplantation*

Note: Indication marked with * is an unapproved indication.

I confirm the above details are correct and that in signing this form I understand I may be audited.

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

Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Budesonide - Cap 3 mg Controlled Release *- continued*

Initial application — non-cirrhotic autoimmune hepatitis
Applications from any relevant practitioner. Approvals valid for 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: Indication marked with * is an unapproved indication.

Renewal

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

Renewal — non-cirrhotic autoimmune hepatitis

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

I confirm the above details are correct and that in signing this form I understand I may be audited.

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

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