Enquiries to Ministry of Health 0800 855 066

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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EANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:			
:	First Names:	First Names:			
	Surname:	Surname:			
S:	DOB:	Address:			
	Address:				
nber:		Fax Number:			
zumab					
Patient has active Crohn's disease  Patient has had an initial app meet renewal criteria (unless  or Patient has a CDAI score of g  or Patient has extensive small in  or Patient has evidence of short or	nt practitioner. Approvals valid for 6 months. ere appropriate)  active Crohn's disease  thas had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to enewal criteria (unless contraindicated)  thas a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10  thas extensive small intestine disease affecting more than 50 cm of the small intestine  thas evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection				
or Patient has experienced intol	nomodulators and corticosteroids erable side effects from immunomodulators and cort				
enewal — Crohn's disease - adults  urrent approval Number (if known):					
:	pplication — Crohn's disease - adults tions from any relevant practitioner. Approv uisites(tick boxes where appropriate)  Patient has active Crohn's disease nd  Patient has had an initial app meet renewal criteria (unless or Patient has extensive small in or Patient has evidence of shore or Patient has evidence of shore or Patient has an ileostomy or cond  Patient has tried but experier from prior therapy with immu or Patient has experienced intol or Immunomodulators and cortical al — Crohn's disease - adults approval Number (if known):	First Names:  Surname:  DOB:  Address:  Address:  Patient has active Crohn's disease - adults ions from any relevant practitioner. Approvals valid for 6 months.  Jisites(tick boxes where appropriate)  Patient has had an initial approval for prior biologic therapy and has experienced meet renewal criteria (unless contraindicated)  Patient has a CDAI score of greater than or equal to 300, or HBI score of greater or Patient has extensive small intestine disease affecting more than 50 cm of the smort patient has evidence of short gut syndrome or would be at risk of short gut syndrome or would be at risk of short gut syndrome or would be at risk of short gut syndrome or would be at risk of short gut syndrome or patient has an ileostomy or colostomy, and has intestinal inflammation  Patient has tried but experienced an inadequate response to (including lack of initing from prior therapy with immunomodulators and corticosteroids  Patient has experienced intolerable side effects from immunomodulators and corticosteroids are contraindicated    Patient has experienced intolerable side effects from immunomodulators and corticosteroids are contraindicated    Cohi's disease - adults approval Number (if known):			

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Reg No:				First Names:	First Names:		
Name:			Surname:	Surname:			
Addre	ss:			DOB:	Address:		
				Address:			
Fax Number:				Fax Number:			
Vedo	lizuı	mab -	continued				
Initial application — Crohn's disease - children* Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)							
			Patient has had an initial ap meet renewal criteria (unles	proval for prior biologic therapy and has experienced s contraindicated)	intolerable side effects or insufficient benefit to		
		or	Patient has a Paediatric Cro	hn's Disease Activity Index (PCDAI) score of greater	than or equal to 30		
		or	Patient has extensive small	all intestine disease			
	and		7				
			Patient has tried but experie from prior therapy with imme	enced an inadequate response to (including lack of ini unomodulators and corticosteroids	tial response and/or loss of initial response)		
		or	Patient has experienced into	olerable side effects from immunomodulators and cort	icosteroids		
		or	Immunomodulators and cor	ticosteroids are contraindicated			
Note:	Indic	cation ma	arked with * is an unapproved i	ndication.			
Rene	wal -	– Crohn	's disease - children*				
Curre	ent ap	proval N	umber (if known):				
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick boxes where appropriate)							
			PCDAI score has reduced b	y 10 points from when the patient was initiated on bio	logic therapy		
		or	PCDAI score is 15 or less				
		or	The patient has experienced	d an adequate response to treatment, but CDAI score	cannot be assessed		
	and	Ved	dolizumab to administered at a	dose no greater than 300mg every 8 weeks			
Note:	India	cation m	arked with * is an unapproved in	ndication			

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

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APPLICANT (stamp or sticker acceptable)		T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Addres	s:		DOB:	Address:	
			Address:		
Fax Number:				Fax Number:	
Vedol	lizur	mab - continued			
Applic Prerec	Initial application — ulcerative colitis Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient has active ulcerative colitis  Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)  Patient has a SCCAI score is greater than or equal to 4  or Patient's PUCAI score is greater than or equal to 20*  and  Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids  or Inmunomodulators and corticosteroids are contraindicated				
Note:	Indic	cation marked with * is an unapproved in	ndication.		
Curre	nt appart	- ulcerative colitis proval Number (if known): s from any relevant practitioner. Approvites (tick boxes where appropriate)			
	and	or The PUCAI score has reduc	ed by 2 points or more from the SCCAI score since in ed by 10 points or more from the PUCAI score since eno greater than 300 mg intravenously every 8 week	initiation on biologic therapy *	
Note:	Note: Indication marked with * is an unapproved indication.				