

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

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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

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Signed: Date:

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