

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Ustekinumab**

**Initial application — Crohn's disease - adults**  
Applications from any relevant practitioner. Approvals valid for 6 months.  
**Prerequisites**(tick boxes where appropriate)

Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment

or

Patient has active Crohn's disease

and

Patient has had an initial approval for prior biologic therapy for Crohn's disease and has experienced intolerable side effects or insufficient benefit to meet renewal criteria

or

Patient meets the initiation criteria for prior biologic therapies for Crohn's disease

and

Other biologics for Crohn's disease are contraindicated

**Renewal — Crohn's disease - adults**  
Current approval Number (if known):.....  
Applications from any relevant practitioner. Approvals valid for 12 months.  
**Prerequisites**(tick boxes where appropriate)

CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy

or

CDAI score is 150 or less, or HBI is 4 or less

or

The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed

and

Ustekinumab to be administered at a dose no greater than 90 mg every 8 weeks

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](mailto:customerservice@health.govt.nz)

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.....      .....

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**Ustekinumab - continued**

**Initial application — Crohn's disease - children\***

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment

**or**

Patient has active Crohn's disease

**and**

Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria

**or**

Patient meets the initiation criteria for prior biologic therapies for Crohn's disease

**and**

Other biologics for Crohn's disease are contraindicated

Note: Indication marked with \* is an unapproved indication.

**Renewal — Crohn's disease - children\***

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy

**or**

PCDAI score is 15 or less

**or**

The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

**and**

Ustekinumab to administered at a dose no greater than 90 mg every 8 weeks

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: .....

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.....	Address: .....	.....
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**Ustekinumab** - *continued*

**Initial application — ulcerative colitis**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	Patient is currently on treatment with ustekinumab commenced prior to 1 February 2023 and met all remaining criteria (criterion 2) below at the time of commencing treatment
<b>or</b>	
<input type="checkbox"/>	Patient has active ulcerative colitis
<b>and</b>	
<input type="checkbox"/>	Patient has had an initial approval for prior biologic therapy for ulcerative colitis and has experienced intolerable side effects or insufficient benefit to meet renewal criteria
<b>or</b>	
<input type="checkbox"/>	Patient meets the initiation criteria for prior biologic therapies for ulcerative colitis
<b>and</b>	
<input type="checkbox"/>	Other biologics for ulcerative colitis are contraindicated

**Renewal — ulcerative colitis**

Current approval Number (if known):.....

Applications from any relevant practitioner. Approvals valid for 12 months.

**Prerequisites**(tick boxes where appropriate)

<input type="checkbox"/>	The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy
<b>or</b>	
<input type="checkbox"/>	PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy*
<b>and</b>	
<input type="checkbox"/>	Ustekinumab will be used at a dose no greater than 90 mg intravenously every 8 weeks

Note: Criterion marked with \* is for an unapproved indication.

**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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