

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

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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