

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

**Enteral liquid peptide formula** (Nutrini Peptisorb; Nutrini Peptisorb Energy)

**Initial application**

Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

☐ Patient has impaired gastrointestinal function and either cannot tolerate polymeric feeds, or polymeric feeds are unsuitable  
**and**

- ☐ Severe malabsorption  
**or**  
☐ Short bowel syndrome  
**or**  
☐ Intractable diarrhoea  
**or**  
☐ Biliary atresia  
**or**  
☐ Cholestatic liver diseases causing malabsorption  
**or**  
☐ Cystic fibrosis  
**or**  
☐ Proven fat malabsorption  
**or**  
☐ Severe intestinal motility disorders causing significant malabsorption  
**or**  
☐ Intestinal failure

☐ The patient is currently receiving funded amino acid formula  
**and**  
☐ The patient is to be trialled on, or transitioned to, an enteral liquid peptide formula

**and**  
☐ A semi-elemental or partially hydrolysed powdered feed has been reasonably trialled and considered unsuitable  
**or**  
☐ For step down from intravenous nutrition

Note: A reasonable trial is defined as a 2-4 week trial.

**Renewal**

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ An assessment as to whether the patient can be transitioned to a cows milk protein or soy infant formula or extensively hydrolysed formula has been undertaken  
**and**  
☐ The outcome of the assessment is that the patient continues to require an enteral liquid peptide formula  
**and**  
☐ General practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted

**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)