Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2535
December 2025

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 without further renewal unless notified.
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 without further renewal unless notified.
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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz

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Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

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 — gut Graft versus Host disease

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.

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