

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:

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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz