

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	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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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)

<input type="checkbox"/> Patient has autoimmune hepatitis*
and
<input type="checkbox"/> Patient does not have cirrhosis
and
<input type="checkbox"/> Diabetes
or
<input type="checkbox"/> Cushingoid habitus
or
<input type="checkbox"/> Osteoporosis where there is significant risk of fracture
or
<input type="checkbox"/> Severe acne following treatment with conventional corticosteroid therapy
or
<input type="checkbox"/> History of severe psychiatric problems associated with corticosteroid treatment
or
<input type="checkbox"/> 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
<input type="checkbox"/> Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)
or
<input type="checkbox"/> 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)

<input type="checkbox"/> 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)

<input type="checkbox"/> 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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