

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER** Reg No: .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

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Fax Number: .....      Fax Number: .....

**Vedolizumab**

**Initial application — Crohn’s disease - adults**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Patient has active Crohn’s disease

**and**

Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10

**or**

Patient has extensive small intestine disease affecting more than 50 cm of the small intestine

**or**

Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection

**or**

Patient has an ileostomy or colostomy, and has intestinal inflammation

**and**

Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

Immunomodulators and corticosteroids are contraindicated

**Renewal — Crohn’s disease - adults**

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy

**or**

CDAI score is 150 or less, or HBI is 4 or less

**or**

The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed

**and**

Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

**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](mailto:customerservice@health.govt.nz)

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**Vedolizumab - continued**

**Initial application — Crohn’s disease - children\***

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Paediatric patient has active Crohn’s disease

**and**

Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

Patient has a Paediatric Crohn’s Disease Activity Index (PCDAI) score of greater than or equal to 30

**or**

Patient has extensive small intestine disease

**and**

Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with \* is an unapproved indication.

**Renewal — Crohn’s disease - children\***

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy

**or**

PCDAI score is 15 or less

**or**

The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

**and**

Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with \* is an unapproved indication.

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**Vedolizumab - continued**

**Initial application — ulcerative colitis**

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

Patient has active ulcerative colitis

**and**

Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

Patient has a SCCAI score is greater than or equal to 4

**or**

Patient's PUCAI score is greater than or equal to 20\*

**and**

Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with \* is an unapproved indication.

**Renewal — ulcerative colitis**

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

Applications from any relevant practitioner. Approvals valid for 2 years.

**Prerequisites**(tick boxes where appropriate)

The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy

**or**

The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy \*

**and**

Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

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: .....

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