

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

or

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