

**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: .....

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