

SA2448 - Ursodeoxycholic Acid

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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:

Ursodeoxycholic Acid

Initial application — Alagille syndrome or progressive familial intrahepatic cholestasis
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- Patient has been diagnosed with Alagille syndrome
or
 Patient has progressive familial intrahepatic cholestasis

Initial application — Chronic severe drug induced cholestatic liver injury
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- Patient has chronic severe drug induced cholestatic liver injury
and
 Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults
and
 Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay

Initial application — Primary biliary cholangitis
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy
and
 Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis)

Initial application — Pregnancy
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

- The patient diagnosed with cholestasis of pregnancy

Initial application — Haematological Transplant
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- Patient at risk of veno-occlusive disease or has hepatic impairment and is undergoing conditioning treatment prior to allogenic stem cell or bone marrow transplantation
and
 Treatment for up to 13 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

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
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Address:	DOB:	Address:
.....	Address:
.....
Fax Number:	Fax Number:

Ursodeoxycholic Acid - continued

Initial application — Total parenteral nutrition induced cholestasis

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

Prerequisites(tick boxes where appropriate)

<input type="checkbox"/> Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by Total Parenteral Nutrition (TPN) and <input type="checkbox"/> Liver function has not improved with modifying the TPN composition
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Renewal — Chronic severe drug induced cholestatic liver injury

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

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

Prerequisites(tick box where appropriate)

The patient continues to benefit from treatment

Renewal — Pregnancy/Primary biliary cholangitis

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

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

Prerequisites(tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Renewal — Total parenteral nutrition induced cholestasis

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

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

Prerequisites(tick box where appropriate)

The paediatric patient continues to require TPN and who is benefiting from treatment, defined as a sustained improvement in bilirubin levels

Initial application — prevention of sinusoidal obstruction syndrome

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites(tick box where appropriate)

The individual has leukaemia/lymphoma and requires prophylaxis for medications/therapies with a high risk of sinusoidal obstruction syndrome

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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