SA2448 - Ursodeoxycholic Acid

APPLICANT (stamp or sticker acceptable)

Reg No: .....

Name: .....

Address: .....

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PATIENT NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

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REFERRER Reg No: .....

First Names: .....

Surname: .....

Address: .....

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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: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
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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)

- ☐ Paediatric patient has developed abnormal liver function as indicated on testing which is likely to be induced by Total Parenteral Nutrition (TPN)

and

- ☐ Liver function has not improved with modifying the TPN composition

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: .....