

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:	
.....		
.....		

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:
.....	Address:	
.....		
.....		

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:

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