

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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:

Budesonide – Cap 3 mg Controlled Release

INITIAL APPLICATION

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Mild to moderate ileal, ileocaecal or proximal Crohn's disease

and

Diabetes

or

Cushingoid habitus

or

Osteoporosis where there is significant risk of fracture

or

Severe acne following treatment with conventional corticosteroid therapy

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 3 months. The patient must have had no more than 1 prior approval in the last year

Prerequisites (tick box where appropriate)

The treatment remains appropriate and the patient is benefiting from treatment

Note:

Clinical trials for Entocort CIR use beyond three months demonstrated no improvement in relapse rate.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: Date:

Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131