

# 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: .....

## Ursodeoxycholic Acid – Cap 300 mg

### INITIAL APPLICATION

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

#### Prerequisites (tick boxes where appropriate)

- Primary biliary cirrhosis 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 > 170umol/l; decompensated cirrhosis)

Note:  
Liver biopsy is not usually required for diagnosis but is helpful to stage the disease.

### RENEWAL

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

Note:  
Actigall is not an appropriate therapy for patients requiring a liver transplant (bilirubin > 170 micromol/l; decompensated cirrhosis). These patients should be referred to an appropriate transplant centre. Treatment failure – doubling of serum bilirubin levels, absence of a significant decrease in ALP or ALT and AST, development of varices, ascites or encephalopathy, marked worsening of pruritus or fatigue, histological progression by two stages, or to cirrhosis, need for transplantation.

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**