

# 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: .....

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Fax Number: .....      Fax Number: .....

## Pegylated Interferon alpha-2A

**INITIAL APPLICATION - chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV**  
Applications from any specialist. Approvals valid for 48 weeks.

**Prerequisites** (tick boxes where appropriate)

Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection

or

Patient has chronic hepatitis C and is co-infected with HIV

Note:

- Consider stopping treatment if there is absence of a virological response (defined as at least a 2-log reduction in viral load) following 12 weeks of treatment since this is predictive of treatment failure.
- Consider reducing treatment to 24 weeks if serum HCV RNA level at Week 4 is undetectable by sensitive PCR assay (less than 50IU/ml) AND Baseline serum HCV RNA is less than 400,000IU/ml

**INITIAL APPLICATION - chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV**  
Applications from any specialist. Approvals valid for 6 months.

**Prerequisites** (tick box where appropriate)

Patient has chronic hepatitis C, genotype 2 or 3 infection

**Use next page for: Initial application - Hepatitis B**

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**

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**Pegylated Interferon alpha-2A - continued**

**INITIAL APPLICATION - Hepatitis B**

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 48 weeks.

**Prerequisites** (tick boxes where appropriate)

Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)

and

Patient is Hepatitis B treatment-naive

and

ALT > 2 times Upper Limit of Normal

and

HBV DNA < 10 log<sub>10</sub> IU/ml

and

HBeAg positive

or

serum HBV DNA ≥ 2,000 units/ml and significant fibrosis (≥ Metavir Stage F2)

and

Compensated liver disease

and

No continuing alcohol abuse or intravenous drug use

and

Not co-infected with HCV, HIV or HDV

and

Neither ALT nor AST > 10 times upper limit of normal

and

No history of hypersensitivity or contraindications to pegylated interferon

**Note:**

- Approved dose is 180 mcg once weekly.
- The recommended dose of Pegylated Interferon-alpha 2a is 180 mcg once weekly.
- In patients with renal insufficiency (calculated creatinine clearance less than 50ml/min), Pegylated Interferon-alpha 2a dose should be reduced to 135 mcg once weekly.
- In patients with neutropaenia and thrombocytopenia, dose should be reduced in accordance with the datasheet guidelines.
- Pegylated Interferon-alpha 2a is not approved for use in children.

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

Signed: ..... Date: .....