SPECIAL AUTHORITY FORMS

June 2012

Contents

Panel Approvals 4
Alimentary Tract and Metabolism 5
Blood and Blood Forming Organs 13
Cardiovascular System 22
Dermatologicals 26
Genito-Urinary System 30
Hormone Preparations - Systemic Excluding Contraceptive Hormones... 36
Infections - Agents for Systemic Use 42
Musculoskeletal System 60
Nervous System 87
Oncology Agents and Immunosuppressants 111
Respiratory System and Allergies 147
Sensory Organs 151
Special Foods 153
List of Forms 191
Index 192

THE SPECIAL AUTHORITY SYSTEM

Special Authority is an application process in which a prescriber requests government subsidy for a particular person.

Criteria

The criteria for approval of Special Authority applications are included below each pharmaceutical listing. For some Special Authority pharmaceuticals, not all indications listed on the data sheets are subsidised. Criteria for each Special Authority pharmaceutical are updated regularly, based on the decision criteria of PHARMAC.

The appropriateness of the listing of a pharmaceutical in the Special Authority category will also be regularly reviewed. Applications for inclusion of further pharmaceuticals in the Special Authority category will generally be made by a pharmaceutical supplier.

Applications from Specialists

"Specialist" means, a doctor who holds a current annual practising certificate and who satisfies the criteria set out below.

a) The doctor's name appears in the Vocational Register of medical practitioners in accordance with Section 21 and 22 of the Medical Practitioners Act 1995 and who is making the application in the course of practising in that area of medicine; and the doctor's vocational branch or sub-branch is one of those listed below:
   - anaesthetics
   - cardiothoracic surgery
   - dermatology
   - diagnostic radiology
   - emergency medicine
   - general surgery
   - internal medicine
   - neurosurgery
   - obstetrics and gynaecology
   - occupational medicine
   - ophthalmology
   - otolaryngology head and neck surgery
   - orthopaedic surgery
   - paediatric surgery
   - paediatrics
   - pathology
   - plastic and reconstructive surgery
   - psychological medicine or psychiatry
   - public health medicine
   - radiation oncology
   - rehabilitation medicine
   - urology and venereology

b) The doctor is recognised by the Ministry of Health as a specialist for the purposes of the Pharmaceutical Schedule and receives remuneration from a DHB at a level which that DHB considers appropriate for specialists and who has written that Prescription in the course of practising in that area of medicine
c) The doctor is recognised by the Ministry of Health as a specialist in relation to a particular area of medicine for the purpose of writing Prescriptions and who has written the Prescription in the course of practising in that area of medicine.
d) The doctor writes the Prescription on DHB stationery and is appropriately authorised by the relevant DHB to do so.

Approval

Special Authority applications are administered by the Ministry of Health. They were formerly administered by Health Payments, Agreements and Compliance (HealthPAC), a division of the Ministry of Health. All applications should be sent, in writing, to:

Ministry of Health, Private Bag 3015, WANGANUI
Fax: (06) 349 1983 or free fax 0800 100 131
For inquiries, please call the Contact Centre on, free phone 0800 243 666

Each application must include:

- name and date of birth of the patient (codes for AIDS patients' applications)
- diagnosis and brief clinical details
- name of the medicine required, the form and strength of the medicine
- duration of the course of treatment
- alternative therapies that have been tried

The application must:

- be signed by the practitioner
- include the practitioner's printed name and address
- show the practitioner's Medical Council registration number
- provide evidence of the criteria as per Special Authority conditions for medicine applied for

Subsidy

Once approved, health providers can obtain the Special Authority approval details for prescribing and dispensing purposes by calling the Contact Centre on 0800 243 666.

Specialists who make an application must communicate the valid authority number to the prescriber who will be writing the prescriptions.

The authority number can provide access to subsidy, additional subsidy, or waive certain restrictions otherwise present on the pharmaceutical.

Some approvals are dependent on the availability of funding.

PANEL APPROVALS

Applications to be made on the approved forms which are available from the co-ordinator of the relevant panel:

Product	Panel
Anti-inflammatory Non Steroidal Drugs (NSAIDs)	PHARMAC
Dasatinib	CML/GIST Co-ordinator
Dornase Alfa	Cystic Fibrosis Advisory Panel
Endothelin Receptor Antagonists	Pulmonary Arterial Hypertension Panel
Iiloprost	Pulmonary Arterial Hypertension Panel
Imatinib Mesylate	CML/GIST Co-ordinator
Imiglucerase	Gaucher's Treatment Panel
Multiple Sclerosis Treatments	Multiple Sclerosis Treatment Committee
Neurontin	PHARMAC
Sildenafil	Pulmonary Arterial Hypertension Panel

Panel Co-ordinator
Pharmac
PO Box 10 254 Wellington
Phone: 04 460 4990 Facsimile: 04 460 4995
E-mail: ECPanel@Pharmac.govt.nz

Product	Panel
Growth Hormone Biosynthetic Human	Growth Hormone Committee

Prof. Wayne Cutfield
National Co-ordinator
New Zealand Growth Hormone Committee
C/- Department of Paediatrics
University of Auckland
Private Bag 92019
AUCKLAND

Alimentary Tract and Metabolism

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1155
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Budesonide - Cap 3 mg Controlled Release

INITIAL APPLICATION - Crohn's disease
Applications from any relevant practitioner. Approvals valid for 6 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
- **or**
- ☐ History of severe psychiatric problems associated with corticosteroid treatment
- **or**
- ☐ History of major mental illness (such as bipolar affective disorder) where the risk of conventional corticosteroid treatment causing relapse is considered to be high
- **or**
- ☐ Relapse during pregnancy (where conventional corticosteroids are considered to be contraindicated)

INITIAL APPLICATION - collagenous and lymphocytic colitis (microscopic colitis)
Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

☐ Patient has a diagnosis of microscopic colitis (collagenous or lymphocytic colitis) by colonoscopy with biopsies

INITIAL APPLICATION - gut Graft versus Host disease
Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

☐ Patient has a gut Graft versus Host disease following allogenic bone marrow transplantation*

Note:
Indication marked with * is an Unapproved Indication.

Use next page for: Renewal

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

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Budesonide - Cap 3 mg Controlled Release - continued

RENEWAL

Current approval Number (if known):..

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

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Pioglitazone

INITIAL APPLICATION - Patients with type 2 diabetes
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ Patient has not achieved glycaemic control on maximum doses of metformin or a sulphonylurea or where either or both are contraindicated or not tolerated

or

☐ Patient is on insulin

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1188
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Ursodeoxycholic Acid

INITIAL APPLICATION - Pregnancy/Cirrhosis
Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient diagnosed with cholestasis of pregnancy

or

- ☐ 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.

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

RENEWAL - Pregnancy/Cirrhosis
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:
Ursodeoxycholic acid 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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0891
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Macrogol 3350 (Movicol)

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

Prerequisites (tick box where appropriate)

❑ the patient has problematic constipation requiring intervention with a per rectal preparation despite an adequate trial of other oral pharmacotherapies including lactulose where lactulose is not contraindicated

RENEWAL

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

❑ the patient is compliant and is continuing to gain benefit from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1002
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Vitabdeck

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ Patient has cystic fibrosis with pancreatic insufficiency

or

☐ Patient is an infant or child with liver disease or short gut syndrome

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1036
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Multivitamins (Paediatric Seravit)

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- ☐ The patient has inborn errors of metabolism

RENEWAL

Current approval Number (if known):...

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- ☐ Patient has had a previous approval for multivitamins

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

Blood and Blood Forming Organs

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0922
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Erythropoietin

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- ☐ patient in chronic renal failure

  and

  Haemoglobin: ....≤ 100g/L

and

- ☐ patient is not diabetic

  and

  glomerular filtration rate: ....≤ 30ml/min

  or

- ☐ patient is diabetic

  and

  glomerular filtration rate: ....≤ 45ml/min

  or

- ☐ patient is on haemodialysis or peritoneal dialysis

RENEWAL
Current approval Number (if known):..
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

Note:
Erythropoietin beta is indicated in the treatment of anaemia associated with chronic renal failure (CRF) where no cause for anaemia other than CRF is detected and there is adequate monitoring of iron stores and iron replacement therapy.

The Cockroft-Gault Formula may be used to estimate glomerular filtration rate (GFR) in persons 18 years and over:

GFR (ml/min) (male) = (140 - age) × Ideal Body Weight (kg) / 814 × serum creatinine (mmol/l)

GFR (ml/min) (female) = Estimated GFR (male) × 0.85

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1201
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Prasugrel

INITIAL APPLICATION - coronary angioplasty and bare metal stent
Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

- ❑ The patient has undergone coronary angioplasty in the previous 4 weeks and is clopidogrel-allergic*

INITIAL APPLICATION - drug eluting stent
Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

- ❑ The patient has had a drug-eluting cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*

INITIAL APPLICATION - stent thromobosis
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- ❑ patient has experienced cardiac stent thrombosis whilst on clopidogrel

RENEWAL - coronary angioplasty and bare metal stent

Current approval Number (if known):..

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

Prerequisites (tick box where appropriate)

- ❑ The patient has undergone coronary angioplasty or had a bare metal cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*

RENEWAL - drug eluting stent

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

- ❑ had a drug-eluting cardiac stent inserted in the previous 4 weeks and is clopidogrel-allergic*

Note:
* Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1174
June 2012

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: ....

Enoxaparin sodium

INITIAL APPLICATION - Pregnancy or Malignancy
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ❑ Low molecular weight heparin treatment is required during a patients pregnancy

or
- ❑ For the treatment of venous thromboembolism where the patient has a malignancy

INITIAL APPLICATION - Venous thromboembolism other than in pregnancy or malignancy
Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites (tick boxes where appropriate)

- ❑ For the short-term treatment of venous thromboembolism prior to establishing a therapeutic INR with oral anti-coagulant treatment

or
- ❑ For the prophylaxis and treatment of venous thromboembolism in high risk surgery

or
- ❑ To enable cessation/re-establishment of existing oral anticoagulant treatment pre/post surgery

or
- ❑ For the prophylaxis and treatment of venous thromboembolism in Acute Coronary Syndrome surgical intervention

or
- ❑ To be used in association with cardioversion of atrial fibrillation

RENEWAL - Pregnancy or Malignancy

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

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ❑ Low molecular weight heparin treatment is required during a patient's pregnancy

or
- ❑ For the treatment of venous thromboembolism where the patient has a malignancy

RENEWAL - Venous thromboembolism other than in pregnancy or malignancy

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

Applications from any relevant practitioner. Approvals valid for 1 month.

Prerequisites (tick box where appropriate)

- ❑ Low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, ACS, cardioversion, or prior to oral anti-coagulation)

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1066
June 2012

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: ....

Rivaroxaban

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 5 weeks.

Prerequisites (tick boxes where appropriate)

❑ For the prophylaxis of venous thromboembolism following a total hip replacement

or

❑ For the prophylaxis of venous thromboembolism following a total knee replacement

Note:
Rivaroxaban is only currently indicated and subsidised for up to 5 weeks therapy for prophylaxis of venous thromboembolism following a total hip replacement and up to 2 weeks therapy for prophylaxis of venous thromboembolism following a total knee replacement.

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 5 weeks.

Prerequisites (tick box where appropriate)

❑ Prophylaxis for venous thromboembolism is required for patients following a subsequent total hip or knee replacement

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1045
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Ezetimibe

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 years
and
☐ Patient's LDL cholesterol is 2.0 mmol/litre or greater
and
- ☐ The patient has rhabdomyolysis (defined as muscle aches and creatine kinase more than 10 × normal) when treated with one statin
  or
- ☐ The patient is intolerant to both simvastatin and atorvastatin
  or
- ☐ The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin

Note:
A patient who has failed to reduce their LDL cholesterol to < 2.0 mmol/litre with the use of a less potent statin should use a more potent statin prior to consideration being given to the use of non-statin therapies.

Other treatment options including fibrates, resins and nicotinic acid should be considered after failure of statin therapy.

If a patient's LDL cholesterol cannot be calculated because the triglyceride level is too high then a repeat test should be performed and if the LDL cholesterol again cannot be calculated then it can be considered that the LDL cholesterol is greater than 2.0 mmol/litre.

Use next page for: Renewal

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1045
June 2012

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: ....

Ezetimibe - continued

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1046
June 2012

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: ....

Ezetimibe with Simvastatin (Vytorin)

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

❑ Patient has a calculated absolute risk of cardiovascular disease of at least 15% over 5 year
and
❑ Patient's LDL cholesterol is 2.0 mmol/litre or greater
and
❑ The patient has not reduced their LDL cholesterol to less than 2.0 mmol/litre with the use of the maximal tolerated dose of atorvastatin

Note:
A patient who has failed to reduce their LDL cholesterol to ≤ 2.0 mmol/litre with the use of a less potent statin should use a more potent statin prior to consideration being given to the use of non-statin therapies.

Other treatment options including fibrates, resins and nicotinic acid should be considered after failure of statin therapy.

If a patient's LDL cholesterol cannot be calculated because the triglyceride level is too high then a repeat test should be performed and if the LDL cholesterol again cannot be calculated then it can be considered that the LDL cholesterol is greater than 2.0 mmol/litre.

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1042
June 2012

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: ....

Deferiprone

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has been diagnosed with chronic transfusional iron overload due to congenital inherited anaemia

Note:
For the purposes of this Special Authority, a relevant specialist is defined as a haematologist.

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

Cardiovascular System

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0933
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Candesartan

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ Patient with congestive heart failure

and

☐ Has been treated with, and cannot tolerate, two ACE inhibitors, due to persistent cough

or

☐ Has experienced angioedema on an ACE inhibitor at any time in the past or who have experienced angioedema (even if not using an ACE inhibitor) in the last 2 years

or

☐ Patient with raised blood pressure

and

☐ Use of fully funded beta blockers or diuretics are contraindicated; or not well tolerated; or insufficient to control blood pressure adequately at appropriate doses

and

☐ Has been treated with, and cannot tolerate, two ACE inhibitors, due to persistent cough

or

☐ Has experienced angioedema on an ACE inhibitor at any time in the past or who have experienced angioedema (even if not using an ACE inhibitor) in the last 2 years

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0934
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Midodrine

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

❑ Disabling orthostatic hypotension not due to drugs

and

❑ Patient has tried fludrocortisone (unless contra-indicated) with unsatisfactory results

and

❑ Patient has tried non pharmacological treatments such as support hose, increased salt intake, exercise, and elevation of head and trunk at night

Note:
Treatment should be started with small doses and titrated upwards as necessary.
Hypertension should be avoided, and the usual target is a standing systolic blood pressure of 90 mm Hg.

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0256
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Perhexiline Maleate

INITIAL APPLICATION
Applications only from a cardiologist or general physician. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ Refractory angina

and

- ☐ Patient is already on maximal anti-anginal therapy

RENEWAL

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

Applications only from a cardiologist or general physician. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Dermatologicals

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0955
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Isotretinoin

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

❑ Patient has had an adequate trial on other available treatments and has received an inadequate response from these treatments or these are contraindicated
and
❑ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice
and
❑ Applicant has an up to date knowledge of the treatment options for acne and is aware of the safety issues around isotretinoin and is competent to prescribe isotretinoin
and
❑ Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of one month after the completion of the treatment
or
❑ Patient is male

Note:
Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

RENEWAL
Current approval Number (if known):..........
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

❑ Patient has had an adequate trial on other available treatments and has received an inadequate response from these treatments or these are contraindicated
and
❑ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice
and
❑ Applicant has an up to date knowledge of the treatment options for acne and is aware of the safety issues around isotretinoin and is competent to prescribe isotretinoin
and
❑ Patient is female and has been counselled and understands the risk of teratogenicity if isotretinoin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of one month after the completion of the treatment
or
❑ Patient is male

Note:
Applicants are recommended to either have used or be familiar with using a decision support tool accredited by their professional body.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0954
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Acitretin

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

❑ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice

and

❑ Applicant has an up to date knowledge of the treatment options for psoriasis and of disorders of keratinisation and is aware of the safety issues around acitretin and is competent to prescribe acitretin

and

❑ Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment

or

❑ Patient is male

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

❑ Applicant is a vocationally registered dermatologist, vocationally registered general practitioner, or nurse practitioner working in a relevant scope of practice

and

❑ Applicant has an up to date knowledge of the treatment options for psoriasis and of disorders of keratinisation and is aware of the safety issues around acitretin and is competent to prescribe acitretin

and

❑ Patient is female and has been counselled and understands the risk of teratogenicity if acitretin is used during pregnancy and the applicant has ensured that the possibility of pregnancy has been excluded prior to the commencement of the treatment and that the patient is informed that she must not become pregnant during treatment and for a period of two years after the completion of the treatment

or

❑ Patient is male

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0923
June 2012

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: ....

Imiquimod

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

❑ The patient has external anogenital warts and podophyllotoxin has been tried and failed (or is contraindicated)
or
❑ The patient has external anogenital warts and podophyllotoxin is unable to be applied accurately to the site
or
❑ The patient has confirmed superficial basal cell carcinoma where other standard treatments, including surgical excision, are contraindicated or inappropriate

Note:
Superficial basal cell carcinoma

- Surgical excision remains first-line treatment for superficial basal cell carcinoma as it has a higher cure rate than imiquimod and allows histological assessment of tumour clearance.
- Imiquimod has not been evaluated for the treatment of superficial basal cell carcinoma within 1 cm of the hairline, eyes, nose, mouth or ears.
- Imiquimod is not indicated for recurrent, invasive, infiltrating, or nodular basal cell carcinoma.

External anogenital warts

- Imiquimod is only indicated for external genital and perianal warts (condyloma acuminata).

RENEWAL
Current approval Number (if known):...
Applications from any relevant practitioner. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

❑ Inadequate response to initial treatment for anogenital warts
or
❑ New confirmed superficial basal cell carcinoma where other standard treatments, including surgical excision, are contraindicated or inappropriate
or
❑ Inadequate response to initial treatment for superficial basal cell carcinoma

Note:
Every effort should be made to biopsy the lesion to confirm that it is a superficial basal cell carcinoma.

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

Genito-Urinary System

Ministry of Health
Phone 0800 243 666

APPLICATION FOR ALTERNATE SUBSIDY BY SPECIAL AUTHORITY

Form SA0500
June 2012

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: ....

Combined oral contraceptives;   Progestogen-only contraceptives (Circle one)

INITIAL APPLICATION
Applications from any medical practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ Patient is on a Social Welfare benefit
or
☐ Patient has an income no greater than the benefit

and
☐ Has tried at least one of the fully funded options and has been unable to tolerate it

RENEWAL

Current approval Number (if known):..

Applications from any medical practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ Patient is on a Social Welfare benefit
or
☐ Patient has an income no greater than the benefit

Note:

The approval numbers of Special Authorities approved after 1 November 1999 are interchangeable between Mercilon and Marvelon.

The additional subsidy will fund Mercilon and Marvelon up to the manufacturer’s price for each of these products as identified on the Schedule at 1 November 1999.

Special Authorities approved before 1 November 1999 remain valid until the expiry date and can be renewed providing that women are still either:

- on a Social Welfare benefit; or
- have an income no greater than the benefit.

The approval numbers of Special Authorities approved before 1 November 1999 are interchangeable for products within the combined oral contraceptives and progestogen-only contraceptives groups, except Loette and Microgynon 20 ED

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0928
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Finasteride

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- [ ] Patient has symptomatic benign prostatic hyperplasia

and

- [ ] The patient is intolerant of non-selective alpha blockers or these are contraindicated

or

- [ ] Symptoms are not adequately controlled with non-selective alpha blockers

Note:
Patients with enlarged prostates are the appropriate candidates for therapy with finasteride.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1032
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Tamsulosin

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ Patient has symptomatic benign prostatic hyperplasia
and
☐ The patient is intolerant of non-selective alpha blockers or these are contraindicated

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1083
June 2012

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: ....

Potassium Citrate

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has recurrent calcium oxalate urolithiasis

and

- ☐ The patient has had more than two renal calculi in the two years prior to the application

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 benefitting from the treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0998
June 2012

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: ....

Solifenacin succinate

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has overactive bladder and a documented intolerance of oxybutynin

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

Hormone Preparations - Systemic Excluding Contraceptive Hormones

Ministry of Health
Phone 0800 243 666

APPLICATION FOR ALTERNATE SUBSIDY BY SPECIAL AUTHORITY

Form SA1018
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Hormone Replacement Therapy - Systemic

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 5 years.

Prerequisites (tick boxes where appropriate)

❑ acute or significant liver disease - where oral oestrogens are contraindicated as determined by a gastroenterologist or general physician. The applicant must keep written confirmation from such a specialist with the patient's record

or

❑ oestrogen induced hypertension requiring antihypertensive therapy - documented evidence must be kept on file that raised blood pressure levels or inability to control blood pressure adequately occurred post oral oestrogens

or

❑ hypertriglyceridaemia - documented evidence must be kept on file that triglyceride levels increased to at least 2 × normal triglyceride levels post oral oestrogens

or

❑ Somatropin co-therapy - patient is being prescribed somatropin with subsidy provided under a valid approval issued under Special Authority

Note:
Prescriptions with a valid Special Authority (CHEM) number will be reimbursed at the level of the lowest priced TDDS product within the specified dose group.

RENEWAL

Current approval Number (if known):...

Applications from any relevant practitioner. Approvals valid for 5 years.

Prerequisites (tick box where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment, or the patient remains on subsidised somatropin co-therapy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0782
June 2012

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: ....

Levonorgestrel – releasing intrauterine system 20µg/24 hr

INITIAL APPLICATION - No previous use
Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ The patient has a clinical diagnosis of heavy menstrual bleeding
and
☐ The patient has failed to respond to or is unable to tolerate other appropriate pharmaceutical therapies as per the Heavy Menstrual Bleeding Guidelines
and

serum ferritin level: ....< 16 µg/l (within the last 12 months)
or
haemoglobin level: ....< 120 g/l

Note:
Applications are not to be made for use in patients as contraception except where they meet the above criteria.

INITIAL APPLICATION - Previous use before 1 October 2002
Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ The patient had a clinical diagnosis of heavy menstrual bleeding
and
☐ Patient demonstrated clinical improvement of heavy menstrual bleeding
and
Applicant to state date of the previous insertion: ....

Note:
Applications are not to be made for use in patients as contraception except where they meet the above criteria.

RENEWAL

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

Applications only from a relevant specialist or general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ Patient demonstrated clinical improvement of heavy menstrual bleeding
or
☐ Previous insertion was removed or expelled within 3 months of insertion
and
Applicant to state date of the previous insertion: ....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1199
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Propylthiouracil

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has hyperthyroidism

and

- ☐ The patient is intolerant of carbimazole or carbimazole is contraindicated

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 benefitting from the treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0090
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Desmopressin – Inj 4 µg per ml, 1 ml

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

❑ The patient cannot use desmopressin nasal spray or nasal drops

RENEWAL

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

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1031
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Cabergoline

INITIAL APPLICATION
Applications only from an obstetrician, endocrinologist or gynaecologist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has pathological hyperprolactinemia

RENEWAL

Current approval Number (if known):..

Applications only from an obstetrician, endocrinologist or gynaecologist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has previously held a valid Special Authority which has expired and the treatment remains appropriate and the patient is benefiting from treatment

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

Infections - Agents for Systemic Use

Ministry of Health
Phone 0800 243 666

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1130
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Azithromycin

INITIAL APPLICATION - Cystic Fibrosis
Applications only from a respiratory specialist or paediatrician. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ The applicant is part of multidisciplinary team experienced in the management of cystic fibrosis

and

- ☐ The patient has been definitively diagnosed with cystic fibrosis*

and

- ☐ The patient has chronic infection with Pseudomonas aeruginosa or Pseudomonas related gram negative organisms as defined by two positive respiratory tract cultures at least three months apart*

and

- ☐ The patient has negative cultures for non-tuberculous mycobacteria

Note:
Caution is advised if using azithromycin as an antibiotic in the treatment of cystic fibrosis patients with pneumonia.
Testing for non-tuberculosis mycobacteria should occur annually.

INITIAL APPLICATION - bronchiolitis obliterans syndrome
Applications only from a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient has received a lung transplant

and

- ☐ Azithromycin is to be used for prophylaxis of bronchiolitis obliterans syndrome*

and

- ☐ The applicant is experienced in managing patients who have received a lung transplant

RENEWAL - bronchiolitis obliterans syndrome
Current approval Number (if known):..
Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ The patient remains well and free from bronchiolits obliterans syndrome*

and

- ☐ The applicant is experienced in managing patients who have received a lung transplant

Note:
Indications marked with * are Unapproved Indications

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1131
June 2012

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: ....

Clarithromycin

INITIAL APPLICATION - Mycobacterial infections
Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ Atypical mycobacterial infection

or

- ☐ Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents

RENEWAL - Mycobacterial infections

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

Applications only from a respiratory specialist, infectious disease specialist or paediatrician. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1065
June 2012

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: ....

Moxifloxacin

INITIAL APPLICATION
Applications only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ Active tuberculosis*

and

- ☐ Documented resistance to one or more first-line medications

or

- ☐ Suspected resistance to one or more first-line medications (tuberculosis assumed to be contracted in an area with known resistance), as part of regimen containing other second-line agents

or

- ☐ Impaired visual acuity (considered to preclude ethambutol use)

or

- ☐ Significant pre-existing liver disease or hepatotoxicity from tuberculosis medications

or

- ☐ Significant documented intolerance and/or side effects following a reasonable trial of first-line medications

or

- ☐ Mycobacterium avium-intracellulare complex not responding to other therapy or where such therapy is contraindicated.*

Note:
Indications marked with * are Unapproved Indications (refer to Section A: General Rules, Part I (Interpretations and Definitions) and Part IV (Miscellaneous Provisions) rule 4.6).

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

Applications only from a respiratory specialist or infectious disease specialist. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1148
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

fluconazole oral liquid

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 6 weeks.

Prerequisites (tick boxes where appropriate)

☐ Patient requires prophlaxis for, or treatment of systemic candidiasis
and
☐ Patient is unable to swallow capsules

RENEWAL

Current approval Number (if known):..

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

Prerequisites (tick boxes where appropriate)

☐ Patient requires prophlaxis for, or treatment of systemic candidiasis
and
☐ Patient is unable to swallow capsules

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0832
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Lamivudine

INITIAL APPLICATION
Applications only from a gastroenterologist, infectious disease specialist, paediatrician or general physician. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ HBsAg positive for more than 6 months

  and
- ☐ HBeAg positive or HBV DNA positive defined as > 100,000 copies per ml by quantitative PCR at a reference laboratory

  and
- ☐ ALT greater than twice upper limit of normal or bridging fibrosis or cirrhosis (Metavir stage 3 or 4 or equivalent) on liver histology clinical/radiological evidence of cirrhosis

or
- ☐ HBV DNA positive cirrhosis prior to liver transplantation

or
- ☐ HBsAg positive and have had a liver, kidney, heart, lung or bone marrow transplant

or
- ☐ Hepatitis B surface antigen positive (HbsAg) patient who is receiving chemotherapy for a malignancy, or who has received such treatment within the previous two months

and
- ☐ No continuing alcohol abuse or intravenous drug use

  and
- ☐ Not coinfected with HCV or HDV

  and
- ☐ Neither ALT nor AST greater than 10 times upper limit of normal

  and
- ☐ No history of hypersensitivity to lamivudine

  and
- ☐ No previous lamivudine therapy with genotypically proven lamivudine resistance

Use next page for: Renewal

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Lamivudine - continued

RENEWAL

Current approval Number (if known):..

Applications only from a gastroenterologist, infectious disease specialist, paediatrician or general physician. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

Renewal for patients who have maintained continuous treatment and response to lamivudine

- ☐ Have maintained continuous treatment with lamivudine

and

- ☐ Most recent test result shows continuing biochemical response (normal ALT)

and

- ☐ HBV DNA <100,00 copies per ml by quantitative PCR at a reference laboratory

or

Renewal when given in combination with adefovir dipivoxil for patients with cirrhosis and resistance to lamivudine

- ☐ Lamivudine to be used in combination with adefovir dipivoxil

and

- ☐ Patient is cirrhotic

and

Documented resistance to lamivudine, defined as:

- ☐ Patient has raised serum ALT (> 1 × ULN)

and

- ☐ Patient has HBV DNA greater than 100,000 copies per mL, or viral load = 10 fold over nadir

and

- ☐ Detection of M204I or M204V mutation

or

Renewal when given in combination with adefovir dipivoxil for patients with resistance to adefovir dipivoxil

- ☐ Lamivudine to be used in combination with adefovir dipivoxil

and

Documented resistance to adefovir, defined as:

- ☐ Patient has raised serum ALT (> 1 × ULN)

and

- ☐ Patient has HBV DNA greater than 100,000 copies per mL, or viral load = 10 fold over nadir

and

- ☐ Detection of N236T or A181T/V mutation

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0829
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adefovir dipivoxil

INITIAL APPLICATION
Applications only from a gastroenterologist or infectious disease specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Patient has confirmed Hepatitis B infection (HBsAg+)
and
Documented resistance to lamivudine, defined as:
☐ Patient has raised serum ALT (> 1 × ULN)
and
☐ Patient has HBV DNA greater than 100,000 copies per mL, or viral load ≥ 10 fold over nadir
and
☐ Detection of M204I or M204V mutation
and

☐ Patient is cirrhotic
and
☐ adefovir dipivoxil to be used in combination with lamivudine

or

☐ Patient is not cirrhotic
and
☐ adefovir dipivoxil to be used as monotherapy

RENEWAL
Current approval Number (if known):..
Applications only from a gastroenterologist or infectious disease specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

☐ In the opinion of the treating physician, treatment remains appropriate and patient is benefiting from treatment

Note:
Lamivudine should be added to adefovir dipivoxil if a patient develops documented resistance to adefovir dipivoxil, defined as:
1. raised serum ALT (> 1 × ULN); and
2. HBV DNA greater than 100,000 copies per mL, or viral load ≥ 10 fold over nadir; and
3. Detection of N236T or A181T/V mutation.

Adefovir dipivoxil should be stopped 6 months following HBeAg seroconversion for patients who were HBeAg+ prior to commencing adefovir dipivoxil.

The recommended dose of adefovir dipivoxil is no more than 10mg daily.

In patients with renal insufficiency adefovir dipivoxil dose should be reduced in accordance with the datasheet guidelines.

Adefovir dipivoxil should be avoided in pregnant women and children.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0977
June 2012

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: ....

Entecavir

INITIAL APPLICATION
Applications only from a gastroenterologist or infectious disease specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

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

and
- ☐ Patient is Hepatitis B nucleoside analogue treatment-naive

and
- ☐ Entecavir dose 0.5 mg/day

and
- ☐ ALT greater than upper limit of normal

  or
- ☐ Bridging fibrosis or cirrhosis (Metavir stage 3 or greater) on liver histology

and
- ☐ HBeAg positive

  or
- ☐ patient has ≥ 2,000 IU HBV DNA units per ml and fibrosis (Metavir stage 2 or greater) on liver histology

and
- ☐ No continuing alcohol abuse or intravenous drug use

and
- ☐ Not co-infected with HCV, HIV or HDV

and
- ☐ Neither ALT nor AST greater than 10 times upper limit of normal

and
- ☐ No history of hypersensitivity to entecavir

and
- ☐ No previous documented lamivudine resistance (either clinical or genotypic)

Note:
- Entecavir should be continued for 6 months following documentation of complete HBeAg seroconversion (defined as loss of HBeAg plus appearance of anti-HBe plus loss of serum HBV DNA) for patients who were HBeAg positive prior to commencing this agent. This period of consolidation therapy should be extended to 12 months in patients with advanced fibrosis (Metavir Stage F3 or F4).
- Entecavir should be taken on an empty stomach to improve absorption.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0957
June 2012

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: ....

Valaciclovir

INITIAL APPLICATION - recurrent genital herpes
Applications from any medical practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

- ☐ The patient has genital herpes with 2 or more breakthrough episodes in any 6 month period while treated with aciclovir 400 mg twice daily

RENEWAL - recurrent genital herpes

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

Applications from any medical practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

INITIAL APPLICATION - ophthalmic zoster
Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- ☐ The patient has previous history of ophthalmic zoster and the patient is at risk of vision impairment

INITIAL APPLICATION - CMV prophylaxis
Applications from any medical practitioner. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

- ☐ The patient has undergone organ 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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1047
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Tenofovir

INITIAL APPLICATION - Confirmed Hepatitis B
Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)
- **and**
- ☐ Patient has had previous lamivudine, adefovir or entecavir therapy
- **and**
- ☐ HBV DNA greater than 20,000 IU/mL or increased ≥ 10 fold over nadir
- **and**
  - ☐ Lamivudine resistance - detection of M204I/V mutation
  - **or**
  - ☐ Adefovir resistance - detection of A181T/V or N236T mutation
  - **or**
  - ☐ Entecavir resistance - detection of relevant mutations including I169T, L180M T184S/A/I/L/G/C/M, S202C/G/I, M204V or M250I/V mutation

or

- ☐ Patient is either listed or has undergone liver transplantation for HBV

INITIAL APPLICATION - Pregnant
Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient is HBsAg positive and pregnant

and

- ☐ HBV DNA > 20,000 IU/mL and ALT > ULN
- **or**
- ☐ HBV DNA > 100 million IU/mL and ALT normal

Use next page for: Renewal - Confirmed Hepatitis B following funded tenofovir treatment for pregnancy within the previous two years and Renewal - Subsequent Pregnancy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Form SA1047
June 2012

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: ....

Tenofovir - continued

RENEWAL - Confirmed Hepatitis B following funded tenofovir treatment for pregnancy within the previous two years

Current approval Number (if known):..

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

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

and

- ☐ Patient has had previous lamivudine, adefovir or entecavir therapy

and

- ☐ HBV DNA greater than 20,000 IU/mL or increased ≥ 10 fold over nadir

and

- ☐ Lamivudine resistance - detection of M204I/V mutation

  or

- ☐ Adefovir resistance - detection of A181T/V or N236T mutation

  or

- ☐ Entecavir resistance - detection of relevant mutations including I169T, L180M T184S/A/I/L/G/C/M, S202C/G/I, M204V or M250I/V mutation

or

- ☐ Patient is either listed or has undergone liver transplantation for HBV

RENEWAL - Subsequent Pregnancy

Current approval Number (if known):..

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient is HBsAg positive and pregnant

and

- ☐ HBV DNA > 20,000 IU/mL and ALT > ULN

  or

- ☐ HBV DNA > 100 million IU/mL and ALT normal

Note:

- Tenofovir disoproxil fumarate should be stopped 6 months following HBeAg seroconversion for patients who were HBeAg positive prior to commencing this agent and 6 months following HBsAg seroconversion for patients who were HBeAg negative prior to commencing this agent.
- The recommended dose of Tenofovir disoproxil fumarate for the treatment of all three indications is 300 mg once daily.
- In patients with renal insufficiency (calculated creatinine clearance less than 50ml/min), Tenofovir disoproxil fumarate dose should be reduced in accordance with the approved Medsafe datasheet guidelines.
- Tenofovir disoproxil fumarate 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: ....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1025
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT (Either patient code or details)
Code/NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Antiretrovirals

INITIAL APPLICATION - Confirmed HIV/AIDS
Applications only from a named specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ Confirmed HIV infection
and
- ☐ Symptomatic patient
- **or**
- ☐ Patient aged 12 months and under
- **or**
  - ☐ Patient aged 1 to 5 years
  - **and**
    - CD4 counts: ....< 1,000 cells/mm³
    - **or**
    - CD4 counts: ....< 0.25 × total lymphocyte count: ....
    - **or**
    - Viral load counts: ....> 100,000 copies per ml
- **or**
  - ☐ Patient aged 6 years and over
  - **and**
  - CD4 counts: ....< 350 cells/mm³

Note:
Tenofovir disoproxil fumarate prescribed under endorsement for HIV/AIDS is included in the count of up to 4 subsidised antiretrovirals.

Subsidies for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

RENEWAL - Confirmed HIV/AIDS
Current approval Number (if known):..

Applications only from a named specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

Use next page for: Initial application - Prevention of maternal transmission, Initial application - post-exposure prophylaxis following non-occupational exposure to HIV, Renewal - second or subsequent post-exposure prophylaxis, Initial application - Percutaneous exposure and Renewal - Second or subsequent percutaneous exposure

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1025
June 2012

APPLICANT (stamp or sticker acceptable)	**PATIENT** (Either patient code or details)	**REFERRER** Reg No: ....
Reg No:	Code/NHI:	First Names: ....
Name:	First Names:	Surname: ....
Address:	Surname:	Address: ....
....	DOB:	....
....	Address:	....
Fax Number:	....	Fax Number: ....

Antiretrovirals - continued

INITIAL APPLICATION - Prevention of maternal transmission
Applications only from a named specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Prevention of maternal foetal transmission

or

☐ Treatment of the newborn for up to eight weeks

Note:

Tenofovir disoproxil fumarate prescribed under endorsement for HIV/AIDS is included in the count of up to 4 subsidised antiretrovirals.

Subsidies for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.

INITIAL APPLICATION - post-exposure prophylaxis following non-occupational exposure to HIV
Applications only from a named specialist. Approvals valid for 4 weeks.

Prerequisites (tick boxes where appropriate)

☐ Treatment course to be initiated within 72 hours post exposure

and

☐ Patient has had unprotected receptive anal intercourse with a known HIV positive person

or

☐ Patient has shared intravenous injecting equipment with a known HIV positive person

Note:

Tenofovir disoproxil fumarate prescribed under endorsement for HIV/AIDS is included in the count of up to 4 subsidised antiretrovirals.

Subsidies for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

RENEWAL - second or subsequent post-exposure prophylaxis

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

Applications only from a named specialist. Approvals valid for 4 weeks.

Prerequisites (tick boxes where appropriate)

☐ Treatment course to be initiated within 72 hours post exposure

and

☐ Patient has had unprotected receptive anal intercourse with a known HIV positive person

or

☐ Patient has shared intravenous injecting equipment with a known HIV positive person

Use next page for: Initial application - Percutaneous exposure and Renewal - Second or subsequent percutaneous exposure

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1025
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT (Either patient code or details)

Code/NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Antiretrovirals - continued

INITIAL APPLICATION - Percutaneous exposure
Applications only from a named specialist. Approvals valid for 6 weeks.

Prerequisites (tick box where appropriate)

- ❑ The patient has percutaneous exposure to blood known to be HIV positive

Note:

Tenofovir disoproxil fumarate prescribed under endorsement for HIV/AIDS is included in the count of up to 4 subsidised antiretrovirals.

Subsidies for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.

RENEWAL - Second or subsequent percutaneous exposure

Current approval Number (if known):..

Applications only from a named specialist. Approvals valid for 6 weeks.

Prerequisites (tick box where appropriate)

- ❑ The patient has percutaneous exposure to blood known to be HIV positive

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0845
June 2012

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: ....

Enfuvirtide

INITIAL APPLICATION
Applications only from a named specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- ☐ Confirmed HIV infection

and

- ☐ Enfuvirtide to be given in combination with optimized background therapy (including at least 1 other antiretroviral drug that the patient has never previously been exposed to) for treatment failure

and

- ☐ Patient has evidence of HIV replication, despite ongoing therapy

  or

- ☐ Patient has treatment-limiting toxicity to previous antiretroviral agents

and

- ☐ Previous treatment with 3 different antiretroviral regimens has failed

and

- ☐ Previous treatment with a non-nucleoside reverse transcriptase inhibitor has failed

  and

- ☐ Previous treatment with a nucleoside reverse transcriptase inhibitor has failed

  and

- ☐ Previous treatment with a protease inhibitor has failed

RENEWAL

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

Applications only from a named specialist. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ Evidence of at least a 10 fold reduction in viral load at 12

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1134
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

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 18 months.

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

and

☐ Maximum of 48 weeks therapy

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 12 months.

Prerequisites (tick boxes where appropriate)

☐ Patient has chronic hepatitis C, genotype 2 or 3 infection

and

☐ Maximum of 6 months therapy

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Pegylated Interferon alpha-2A - continued

INITIAL APPLICATION - Hepatitis B
Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.

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 log10 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
and
☐ Maximum of 48 weeks therapy

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 thrombocytopaenia, 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: ....

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

Musculoskeletal System

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1034
June 2012

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: ....

Meloxicam

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

❑ The patient has moderate to severe haemophilia with less than or equal to 5% of normal circulating functional clotting factor

and

❑ The patient has haemophilic arthropathy

and

❑ Pain and inflammation associated with haemophilic arthropathy is inadequately controlled by alternative funded treatment options, or alternative funded treatment options are contraindicated

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Etanercept

INITIAL APPLICATION - juvenile idiopathic arthritis
Applications only from a named specialist or rheumatologist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

☐ To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

and

☐ Patient diagnosed with Juvenile Idiopathic Arthritis (JIA)

and

☐ Patient has had severe active polyarticular course JIA for 6 months duration or longer

and

☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate (at a dose of 10-20 mg/m² weekly or at the maximum tolerated dose) in combination with either oral corticosteroids (prednisone 0.25 mg/kg or at the maximum tolerated dose) or a full trial of serial intra-articular corticosteroid injections

and

- ☐ Patient has persistent symptoms of poorly-controlled and active disease in at least 20 swollen, tender joints

  or

  ☐ Patient has persistent symptoms of poorly-controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, shoulder, cervical spine, hip

and

☐ Physician's global assessment indicating severe disease

Use next page for: Initial application - rheumatoid arthritis, Initial application - severe chronic plaque psoriasis, Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - juvenile idiopathic arthritis, Renewal - rheumatoid arthritis, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Etanercept - continued

INITIAL APPLICATION - rheumatoid arthritis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for adalimumab for rheumatoid arthritis
- **and**
  - ☐ The patient has experienced intolerable side effects from adalimumab
  - **or**
  - ☐ The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for rheumatoid arthritis

or

- ☐ Patient has had severe and active erosive rheumatoid arthritis for six months duration or longer
- **and**
- ☐ Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance
- **and**
- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose
- **and**
- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulphasalazine and hydroxychloroquine sulphate (at maximum tolerated doses)
- **and**
  - ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin
  - **or**
  - ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold
  - **or**
  - ☐ Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate
- **and**
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints
  - **or**
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
- **and**
  - ☐ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
  - **or**
  - ☐ C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Use next page for: Initial application - severe chronic plaque psoriasis, Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - juvenile idiopathic arthritis, Renewal - rheumatoid arthritis, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Etanercept - continued

INITIAL APPLICATION - severe chronic plaque psoriasis
Applications only from a dermatologist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- ❑ The patient has had an initial Special Authority approval for adalimumab for severe chronic plaque psoriasis

  and

  - ❑ The patient has experienced intolerable side effects from adalimumab

    or

  - ❑ The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe chronic plaque psoriasis

or

- ❑ Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 15, where lesions have been present for at least 6 months from the time of initial diagnosis

  or

- ❑ Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis

and

- ❑ Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin

and

- ❑ A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

and

- ❑ The most recent PASI assessment is no more than 1 month old at the time of application

Note:
"Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 15, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Use next page for: Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - juvenile idiopathic arthritis, Renewal - rheumatoid arthritis, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Etanercept - continued

INITIAL APPLICATION - ankylosing spondylitis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ❑ The patient has had an initial Special Authority approval for adalimumab for ankylosing spondylitis

  and

  - ❑ The patient has experienced intolerable side effects from adalimumab

    or

  - ❑ The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for ankylosing spondylitis

or

- ❑ Patient has a confirmed diagnosis of ankylosing spondylitis present for more than six months

  and

- ❑ Patient has low back pain and stiffness that is relieved by exercise but not by rest

  and

- ❑ Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan

  and

- ❑ Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of an exercise regime supervised by a physiotherapist

  and

  - ❑ Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Bath Ankylosing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)

    or

  - ❑ Patient has limitation of chest expansion by at least 2.5 cm below the average normal values corrected for age and gender (see Notes)

  and

- ❑ A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale

Note:

The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI measure must be no more than 1 month old at the time of initial application.

Average normal chest expansion corrected for age and gender:

18-24 years - Male: 7.0 cm; Female: 5.5 cm

25-34 years - Male: 7.5 cm; Female: 5.5 cm

35-44 years - Male: 6.5 cm; Female: 4.5 cm

45-54 years - Male: 6.0 cm; Female: 5.0 cm

55-64 years - Male: 5.5 cm; Female: 4.0 cm

65-74 years - Male: 4.0 cm; Female: 4.0 cm

75+ years - Male: 3.0 cm; Female: 2.5 cm

Use next page for: Initial application - psoriatic arthritis, Renewal - juvenile idiopathic arthritis, Renewal - rheumatoid arthritis, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

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: ....

Etanercept - continued

INITIAL APPLICATION - psoriatic arthritis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ❑ The patient has had an initial Special Authority approval for adalimumab for psoriatic arthritis

  and

  - ❑ The patient has experienced intolerable side effects from adalimumab

    or

  - ❑ The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for psoriatic arthritis

or

- ❑ Patient has had severe active psoriatic arthritis for six months duration or longer

  and

- ❑ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose

  and

- ❑ Patient has tried and not responded to at least three months of sulphasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)

  and

  - ❑ Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints

    or

  - ❑ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

  and

  - ❑ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application

    or

  - ❑ Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour

    or

  - ❑ ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Use next page for: Renewal - juvenile idiopathic arthritis, Renewal - rheumatoid arthritis, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Etanercept - continued

RENEWAL - juvenile idiopathic arthritis

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

Applications only from a named specialist, rheumatologist or Practitioner on the recommendation of a named specialist or rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a named specialist or rheumatologist

or

- ☐ Applicant is a Practitioner and confirms that a named specialist or rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment

and

- ☐ Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

and

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline

or

- ☐ On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline

RENEWAL - rheumatoid arthritis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a rheumatologist

or

- ☐ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment

and

- ☐ Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

and

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

or

- ☐ On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

and

- ☐ Etanercept to be administered at doses no greater than 50 mg every 7 days

Use next page for: Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Etanercept - continued

RENEWAL - severe chronic plaque psoriasis

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

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a dermatologist

or

- ☐ Applicant is a Practitioner and confirms that a dermatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment

and

- ☐ Patient had "whole body" severe chronic plaque psoriasis at the start of treatment

  and

- ☐ Following each prior etanercept treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-treatment baseline value

or

- ☐ Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment

  and

  - ☐ Following each prior etanercept treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values

    or

  - ☐ Following each prior etanercept treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value

and

- ☐ Etanercept to be administered at doses no greater than 50 mg every 7 days

Note:
A treatment course is defined as a minimum of 12 weeks of etanercept treatment

Use next page for: Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1157
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Etanercept - continued

RENEWAL - ankylosing spondylitis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a rheumatologist

  or

- ☐ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment

and

- ☐ Following 12 weeks of etanercept treatment, BASDAI has improved by 4 or more points from pre-treatment baseline on a 10 point scale, or by 50%, whichever is less

and

- ☐ Physician considers that the patient has benefited from treatment and that continued treatment is appropriate

and

- ☐ Etanercept to be administered at doses no greater than 50 mg every 7 days

RENEWAL - psoriatic arthritis

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

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a rheumatologist

  or

- ☐ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with etanercept treatment

and

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

  or

- ☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician

and

- ☐ Etanercept to be administered at doses no greater than 50 mg every 7 days

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab

INITIAL APPLICATION - rheumatoid arthritis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for etanercept for rheumatoid arthritis

  and
  - ☐ The patient has experienced intolerable side effects from etanercept

    or
  - ☐ The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for rheumatoid arthritis

or

- ☐ Patient has had severe and active erosive rheumatoid arthritis for six months duration or longer

  and
- ☐ Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

  and
- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose

  and
- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulphasalazine and hydroxychloroquine sulphate (at maximum tolerated doses)

  and
  - ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the maximum tolerated dose of cyclosporin

    or
  - ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with intramuscular gold

    or
  - ☐ Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with oral or parenteral methotrexate

  and
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least 20 swollen, tender joints

    or
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

  and
  - ☐ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application

    or
  - ☐ C-reactive protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Use next page for: Initial application - Crohn's disease, Initial application - severe chronic plaque psoriasis, Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab - continued

INITIAL APPLICATION - Crohn's disease
Applications only from a gastroenterologist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

☐ Patient has severe active Crohn's disease

and

- ☐ Patient has a Crohn's Disease Activity Index (CDAI) score of greater than or equal to 300

  or
- ☐ Patient has extensive small intestine disease affecting more than 50 cm of the small intestine

  or
- ☐ Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection

  or
- ☐ Patient has an ileostomy or colostomy, and has intestinal inflammation

and

☐ Patient has tried but had an inadequate response to, or has experienced intolerable side effects from, prior systemic therapy with immunomodulators at maximum tolerated doses (unless contraindicated) and corticosteroids

and

☐ Surgery (or further surgery) is considered to be clinically inappropriate

Use next page for: Initial application - severe chronic plaque psoriasis, Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

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: ....

Adalimumab - continued

INITIAL APPLICATION - severe chronic plaque psoriasis
Applications only from a dermatologist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for etanercept for severe chronic plaque psoriasis

  and
  - ☐ The patient has experienced intolerable side effects from etanercept

    or
  - ☐ The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for severe chronic plaque psoriasis

or

- - ☐ Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 15, where lesions have been present for at least 6 months from the time of initial diagnosis

    or
  - ☐ Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis

  and
- ☐ Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, cyclosporin, or acitretin

  and
- ☐ A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

  and
- ☐ The most recent PASI assessment is no more than 1 month old at the time of application

Note:
"Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 15, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand or foot, at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.

Use next page for: Initial application - ankylosing spondylitis, Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab - continued

INITIAL APPLICATION - ankylosing spondylitis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ❑ The patient has had an initial Special Authority approval for etanercept for ankylosing spondylitis

  and
  - ❑ The patient has experienced intolerable side effects from etanercept

    or
  - ❑ The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for ankylosing spondylitis

or

- ❑ Patient has a confirmed diagnosis of ankylosing spondylitis for more than six months

  and
- ❑ Patient has low back pain and stiffness that is relieved by exercise but not by rest

  and
- ❑ Patient has bilateral sacroiliitis demonstrated by plain radiographs, CT or MRI scan

  and
- ❑ Patient's ankylosing spondylitis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory drugs (NSAIDs), in combination with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of an exercise regime supervised by a physiotherapist

  and
  - ❑ Patient has limitation of motion of the lumbar spine in the sagittal and the frontal planes as determined by the following Bath Ankylosing Spondylitis Metrology Index (BASMI) measures: a modified Schober's test of less than or equal to 4 cm and lumbar side flexion measurement of less than or equal to 10 cm (mean of left and right)

    or
  - ❑ Patient has limitation of chest expansion by at least 2.5 cm below the following average normal values corrected for age and gender (see Notes)

  and
- ❑ A Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) of at least 6 on a 0-10 scale

Note:
The BASDAI must have been determined at the completion of the 3 month exercise trial, but prior to ceasing NSAID treatment. The BASDAI measure must be no more than 1 month old at the time of initial application.

Average normal chest expansion corrected for age and gender:

18-24 years - Male: 7.0 cm; Female: 5.5 cm

25-34 years - Male: 7.5 cm; Female: 5.5 cm

35-44 years - Male: 6.5 cm; Female: 4.5 cm

45-54 years - Male: 6.0 cm; Female: 5.0 cm

55-64 years - Male: 5.5 cm; Female: 4.0 cm

65-74 years - Male: 4.0 cm; Female: 4.0 cm

75+ years - Male: 3.0 cm; Female: 2.5 cm

Use next page for: Initial application - psoriatic arthritis, Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab - continued

INITIAL APPLICATION - psoriatic arthritis
Applications only from a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for etanercept for psoriatic arthritis
- **and**
  - ☐ The patient has experienced intolerable side effects from etanercept
  - **or**
  - ☐ The patient has received insufficient benefit from etanercept to meet the renewal criteria for etanercept for psoriatic arthritis

or

- ☐ Patient has had severe active psoriatic arthritis for six months duration or longer
- **and**
- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose
- **and**
- ☐ Patient has tried and not responded to at least three months of sulphasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)
- **and**
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints
  - **or**
  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip
- **and**
  - ☐ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application
  - **or**
  - ☐ Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour
  - **or**
  - ☐ ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

Use next page for: Renewal - rheumatoid arthritis, Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Adalimumab - continued

RENEWAL - rheumatoid arthritis

Current approval Number (if known):...

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ❑ Applicant is a rheumatologist

or

- ❑ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

- ❑ Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance

and

- ❑ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

or

- ❑ On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

and

- ❑ Adalimumab to be administered at doses no greater than 40 mg every 14 days

or

- ❑ Patient cannot take concomitant methotrexate and requires doses of adalimumab higher than 40 mg every 14 days to maintain an adequate response

Use next page for: Renewal - Crohn's disease, Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Adalimumab - continued

RENEWAL - Crohn's disease

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

Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- ☐ Applicant is a gastroenterologist

or

- ☐ Applicant is a Practitioner and confirms that a gastroenterologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

- ☐ CDAI score has reduced by 100 points from the CDAI score when the patient was initiated on adalimumab

  or

- ☐ CDAI score is 150 or less

or

- ☐ The patient has demonstrated an adequate response to treatment but CDAI score cannot be assessed

  and

  Applicant to indicate the reason that CDAI score cannot be assessed: ....

and

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

Use next page for: Renewal - severe chronic plaque psoriasis, Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1156
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab - continued

RENEWAL - severe chronic plaque psoriasis

Current approval Number (if known):..

Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a dermatologist

or

- ☐ Applicant is a Practitioner and confirms that a dermatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

- ☐ Patient had "whole body" severe chronic plaque psoriasis at the start of treatment

  and

- ☐ Following each prior adalimumab treatment course the patient has a PASI score which is reduced by 75% or more, or is sustained at this level, when compared with the pre-adalimumab treatment baseline value

or

- ☐ Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment

  and

  - ☐ Following each prior adalimumab treatment course the patient has a reduction in the PASI symptom subscores for all 3 of erythema, thickness and scaling, to slight or better, or sustained at this level, as compared to the treatment course baseline values

    or

  - ☐ Following each prior adalimumab treatment course the patient has a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-adalimumab treatment baseline value

and

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

Note:
A treatment course is defined as a minimum of 12 weeks adalimumab treatment

Use next page for: Renewal - ankylosing spondylitis and Renewal - psoriatic arthritis

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

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adalimumab - continued

RENEWAL - ankylosing spondylitis

Current approval Number (if known):..

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a rheumatologist

  or

- ☐ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

- ☐ Following 12 weeks of adalimumab treatment, BASDAI has improved by 4 or more points from pre-adalimumab baseline on a 10 point scale, or by 50%, whichever is less

and

- ☐ Physician considers that the patient has benefited from treatment and that continued treatment is appropriate

and

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

RENEWAL - psoriatic arthritis

Current approval Number (if known):..

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Applicant is a rheumatologist

  or

- ☐ Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fax recommending that the patient continues with adalimumab treatment

and

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

  or

- ☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior adalimumab treatment in the opinion of the treating physician

and

- ☐ Adalimumab to be administered at doses no greater than 40 mg every 14 days

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1039
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Alendronate Tab 70 mg - with or without Cholecalciferol

INITIAL APPLICATION - Underlying cause -- Osteoporosis
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

❑ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5) (see Note)

or

❑ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

❑ History of two significant osteoporotic fractures demonstrated radiologically

or

❑ Documented T-Score ≤ -3.0 (see Note)

or

❑ A 10-year risk of hip fracture ≥ 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

❑ Patient has had a Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or raloxifene

INITIAL APPLICATION - Underlying cause -- glucocorticosteroid therapy
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

❑ The patient is receiving systemic glucocorticosteriod therapy (≥5 mg per day prednisone equivalents) and has already received or is expected to receive therapy for at least three months

and

- ❑ The patient has documented BMD ≥ 1.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -1.5) (see Note)

  or

- ❑ The patient has a history of one significant osteoporotic fracture demonstrated radiologically

  or

- ❑ The patient has had a Special Authority approval for zoledronic acid (Underlying cause - glucocorticosteroid therapy) or raloxifene

Use next page for: Renewal - Underlying cause was, and remains, glucocorticosteroid therapy and Renewal - Underlying cause was glucocorticosteroid therapy but patient now meets the `Underlying cause - osteoporosis' criteria

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1039
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Alendronate Tab 70 mg - with or without Cholecalciferol - continued

RENEWAL - Underlying cause was, and remains, glucocorticosteroid therapy

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

❑ The patient is continuing systemic glucocorticosteriod therapy (≥5 mg per day prednisone equivalents)

RENEWAL - Underlying cause was glucocorticosteroid therapy but patient now meets the `Underlying cause - osteoporosis' criteria

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

❑ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5) (see Note)

or

❑ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

❑ History of two significant osteoporotic fractures demonstrated radiologically

or

❑ Documented T-Score ≤ -3.0 (see Note)

or

❑ A 10-year risk of hip fracture ≥ 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

❑ Patient has had a Special Authority approval for zoledronic acid (Underlying cause was glucocorticosteroid therapy but patient now meets the `Underlying cause - Osteoporosis' criteria) or raloxifene

Note:

a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
b) Evidence used by National Institute for Health and Clinical Excellence (NICE) guidance indicates that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score ≤ -2.5 and, therefore, do not require BMD measurement for treatment with bisphosphonates.
c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
d) In line with the Australian guidelines for funding alendronate, a vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0949
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Alendronate for Paget's Disease (Alendronate Tab 40 mg)

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

Prerequisites (tick boxes where appropriate)

☐ Paget's disease

and

- ☐ Bone or articular pain

  or
- ☐ Bone deformity

  or
- ☐ Bone, articular or neurological complications

  or
- ☐ Asymptomatic disease, but risk of complications due to site (base of skull, spine, long bones of lower limbs)

  or
- ☐ Preparation for orthopaedic surgery

RENEWAL

Current approval Number (if known):..

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

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1187
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Zoledronic acid

INITIAL APPLICATION - Paget's disease
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Paget's disease

and

☐ Bone or articular pain

or

☐ Bone deformity

or

☐ Bone, articular or neurological complications

or

☐ Asymptomatic disease, but risk of complications

or

☐ Preparation for orthopaedic surgery

and

☐ The patient will not be prescribed more than one infusion in the 12-month approval period

INITIAL APPLICATION - Underlying cause - Osteoporosis
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5) (see Note)

or

☐ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

☐ History of two significant osteoporotic fractures demonstrated radiologically

or

☐ Documented T-Score ≤ -3.0 (see Note)

or

☐ A 10-year risk of hip fracture ≥ 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

☐ Patient has had a Special Authority approval for alendronate (Underlying cause - Osteoporosis) or raloxifene

and

☐ The patient will not be prescribed more than one infusion in a 12-month period

Use next page for: Initial application - Underlying cause - glucocorticosteroid therapy, Renewal - Paget's disease, Renewal - Underlying cause was, and remains, glucocorticosteroid therapy and Renewal - Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria

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

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Zoledronic acid - continued

INITIAL APPLICATION - Underlying cause - glucocorticosteroid therapy
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ The patient is receiving systemic glucocorticosteroid therapy (≥5 mg per day prednisone equivalents) and has already received or is expected to receive therapy for at least three months

and

- ☐ The patient has documented BMD ≥ 1.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -1.5) (see Note)

or

- ☐ The patient has a history of one significant osteoporotic fracture demonstrated radiologically

or

- ☐ The patient has had a Special Authority approval for alendronate (Underlying cause - glucocorticosteroid therapy) or raloxifene

and

- ☐ The patient will not be prescribed more than one infusion in the 12-month approval period

RENEWAL - Paget's disease

Current approval Number (if known):...

Applications from any relevant practitioner. Approvals valid for 1 year. The patient must have had no more than 1 prior approval in the last 12 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient has relapsed (based on increases in serum alkaline phosphatase)

or

- ☐ The patient's serum alkaline phosphatase has not normalised following previous treatment with zoledronic acid

or

- ☐ Symptomatic disease (prescriber determined)

and

- ☐ The patient will not be prescribed more than one infusion in the 12-month approval period

RENEWAL - Underlying cause was, and remains, glucocorticosteroid therapy

Current approval Number (if known):...

Applications from any relevant practitioner. Approvals valid for 1 year. The patient must have had no more than 1 prior approval in the last 12 months

Prerequisites (tick boxes where appropriate)

- ☐ The patient is continuing systemic glucocorticosteriod therapy (≥5 mg per day prednisone equivalents)

and

- ☐ The patient will not be prescribed more than one infusion in the 12-month approval period

Use next page for: Renewal - Underlying cause was glucocorticosteroid therapy but patient now meets the ‘Underlying cause - osteoporosis' criteria

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1187
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Zoledronic acid - continued

RENEWAL - Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - osteoporosis' criteria

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

❑ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) ≥ 2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5) (see Note)

or

❑ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

❑ History of two significant osteoporotic fractures demonstrated radiologically

or

❑ Documented T-Score ≤ -3.0 (see Note)

or

❑ A 10-year risk of hip fracture ≥ 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Note)

or

❑ Patient has had a Special Authority approval for alendronate (Underlying cause was glucocorticosteroid therapy but patient now meets the 'Underlying cause - Osteoporosis' criteria) or raloxifene

and

❑ The patient will not be prescribed more than one infusion in a 12-month period

Note:

a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
b) Evidence used by National Institute for Health and Clinical Excellence (NICE) guidance indicates that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score ≤ -2.5 and, therefore, do not require BMD measurement for treatment with bisphosphonates.
c) Osteoporotic fractures are the incident events for severe (established) osteoporosis and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1138
June 2012

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: ....

Raloxifene

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

❑ History of one significant osteoporotic fracture demonstrated radiologically and documented bone mineral density (BMD) ≥2.5 standard deviations below the mean normal value in young adults (i.e. T-Score ≤ -2.5) (see Notes)

or

❑ History of one significant osteoporotic fracture demonstrated radiologically, and either the patient is elderly, or densitometry scanning cannot be performed because of major logistical, technical or pathophysiological reasons. It is unlikely that this provision would apply to many patients under 75 years of age

or

❑ History of two significant osteoporotic fractures demonstrated radiologically

or

❑ Documented T-Score ≤ -3.0 (see Notes)

or

❑ A 10-year risk of hip fracture ≥ 3%, calculated using a published risk assessment algorithm (e.g. FRAX or Garvan) which incorporates BMD measurements (see Notes)

or

❑ Patient has had a prior Special Authority approval for zoledronic acid (Underlying cause - Osteoporosis) or alendronate (Underlying cause - Osteoporosis)

Note:

a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
b) Evidence used by the UK National Institute for Health and Clinical Excellence (NICE) in developing its guidance indicates that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score ≤ -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1139
June 2012

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: ....

Teriparatide

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 18 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has severe, established osteoporosis

and

- ☐ The patient has a documented T-score less than or equal to -3.0 (see Notes)

and

- ☐ The patient has had two or more fractures due to minimal trauma

and

- ☐ The patient has experienced at least one symptomatic new fracture after at least 12 months' continuous therapy with a funded antiresorptive agent at adequate doses (see Notes)

Note:

a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
b) Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: alendronate sodium tab 70 mg or tab 70 mg with cholecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
d) A maximum of 18 months of treatment (18 cartridges) will be subsidised.

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

Nervous System

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0906
June 2012

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: ....

Lignocaine with Prilocaine

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

- ☐ the patient is a child with a chronic medical condition requiring frequent injections or venepuncture

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1048
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Mianserin Hydrochloride

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ Depression

  and

  - ☐ Co-existent bladder neck obstruction

    or

  - ☐ Cardiovascular disease

or

- ☐ The patient has a severe major depressive episode

  and

  - ☐ The patient must have had a trial of two different antidepressants and was unable to tolerate the treatments or failed to respond to an adequate dose over an adequate period of time (usually at least four weeks)

    or

    - ☐ The patient is currently a hospital in-patient as a result of an acute depressive episode

      and

    - ☐ The patient must have had a trial of one other antidepressant and either could not tolerate it or failed to respond to an adequate dose over an adequate period of time

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1061
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Venlafaxine

INITIAL APPLICATION
Applications only from a relevant specialist or vocationally registered general practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has 'treatment-resistant' depression

and

- ☐ The patient must have had a trial of two different antidepressants and have had an inadequate response from an adequate dose over an adequate period of time (usually at least four weeks)

or

- ☐ The patient is currently a hospital in-patient as a result of an acute depressive episode

and

- ☐ The patient must have had a trial of one other antidepressant and have had an inadequate response from an adequate dose over an adequate period of time

RENEWAL

Current approval Number (if known):..

Applications from any medical practitioner. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

- ☐ The patient has a high risk of relapse (prescriber determined)

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0994
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Mirtazapine

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ The patient has a severe major depressive episode

and

☐ The patient must have had a trial of two different antidepressants and was unable to tolerate the treatments or failed to respond to an adequate dose over an adequate period of time (usually at least four weeks)

or

☐ The patient is currently a hospital in-patient as a result of an acute depressive episode

and

☐ The patient must have had a trial of one other antidepressant and either could not tolerate it or failed to respond to an adequate dose over an adequate period of time

RENEWAL

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

☐ The patient has a high risk of relapse (prescriber determined)

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1072
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Vigabatrin

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient has infantile spasms

or

- ☐ Patient has epilepsy

  and

  - ☐ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents

    or

  - ☐ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

and

- ☐ Patient is, or will be, receiving regular automated visual field testing (ideally before starting therapy and on a 6-monthly basis thereafter)

or

- ☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

Note:
``Optimal treatment with other antiepilepsy agents'' is defined as treatment with other antiepilepsy agents which are indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight, and other features affecting the pharmacokinetics of the drug with good evidence of compliance.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and or quality of life

and

- ☐ Patient is receiving regular automated visual field testing (ideally every 6 months) on an ongoing basis for duration of treatment with vigabatrin

or

- ☐ It is impractical or impossible (due to comorbid conditions) to monitor the patient's visual fields

Note:
As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

Vigabatrin is associated with a risk of irreversible visual field defects, which may be asymptomatic in the early stages.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1071
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Gabapentin

INITIAL APPLICATION - Epilepsy
Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

☐ Seizures are not adequately controlled with optimal treatment with other antiepilepsy agents

or

☐ Seizures are controlled adequately but the patient has experienced unacceptable side effects from optimal treatment with other antiepilepsy agents

Note:
"Optimal treatment with other antiepilepsy agents" is defined as treatment with other antiepilepsy agents which are indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight, and other features affecting the pharmacokinetics of the drug with good evidence of compliance.

INITIAL APPLICATION - Neuropathic pain
Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

☐ The patient has tried and failed, or has been unable to tolerate, treatment with a tricyclic antidepressant

RENEWAL - Epilepsy

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

☐ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life

Note:
As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

RENEWAL - Neuropathic pain

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

Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ The patient has demonstrated a marked improvement in their control of pain (prescriber determined)

or

☐ The patient has previously demonstrated clinical responsiveness to gabapentin and has now developed neuropathic pain in a new site

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1125
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Lacosamide

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

❑ Patient has partial-onset epilepsy
and
❑ Seizures are not adequately controlled by, or patient has experienced unacceptable side effects from, optimal treatment with all of the following: sodium valproate, topiramate, levetiracetam and any two of carbamazepine, lamotrigine and phenytoin sodium (see Note)

Note:
"Optimal treatment" is defined as treatment which is indicated and clinically appropriate for the patient, given in adequate doses for the patient's age, weight and other features affecting the pharmacokinetics of the drug with good evidence of compliance. Women of childbearing age are not required to have a trial of sodium valproate.

RENEWAL
Current approval Number (if known):...
Applications from any relevant practitioner. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

❑ The patient has demonstrated a significant and sustained improvement in seizure rate or severity and/or quality of life compared with that prior to starting lacosamide treatment (see Note)

Note:
As a guideline, clinical trials have referred to a notional 50% reduction in seizure frequency as an indicator of success with anticonvulsant therapy and have assessed quality of life from the patient's perspective.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0939
June 2012

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: ....

Hyoscine (Scopolamine)

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

❑ Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease
and
❑ Patient cannot tolerate or does not adequately respond to oral anti-nausea agents
and
The applicant must specify the underlying malignancy or chronic disease: ....

RENEWAL

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0987
June 2012

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: ....

Aprepitant

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

❑ The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

❑ The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0920
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Aripiprazole

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

❑ Patient is suffering from schizophrenia or related psychoses

and

❑ An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of unacceptable side effects

or

❑ An effective dose of risperidone or quetiapine has been trialled and has been discontinued, or is in the process of being discontinued, because of inadequate clinical response

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0926
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Risperidone microspheres

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

Prerequisites (tick boxes where appropriate)

- [ ] The patient has schizophrenia or other psychotic disorder

and

- [ ] Has tried but failed to comply with treatment using oral atypical antipsychotic agents

and

- [ ] Has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in last 12 months

RENEWAL

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has had less than 12 months treatment with risperidone depot injection

and

- [ ] There is no clinical reason to discontinue treatment

or

- [ ] The initiation of risperidone depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of risperidone depot injection

Note:
Risperidone depot injection should ideally be used as monotherapy (i.e. without concurrent use of any other antipsychotic medication). In some cases, it may be clinically appropriate to attempt to treat a patient with typical antipsychotic agents in depot injectable form before trialing risperidone depot injection.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1146
June 2012

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: ....

Olanzapine depot injection

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

Prerequisites (tick boxes where appropriate)

- ☐ The patient has schizophrenia

and

- ☐ The patient has tried but failed to comply with treatment using oral atypical antipsychotic agents

and

- ☐ The patient has been admitted to hospital or treated in respite care, or intensive outpatient or home-based treatment for 30 days or more in the last 12 months

RENEWAL

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has had less than 12 months' treatment with olanzapine depot injection

  and

- ☐ There is no clinical reason to discontinue treatment

or

- ☐ The initiation of olanzapine depot injection has been associated with fewer days of intensive intervention than was the case during a corresponding period of time prior to the initiation of olanzapine depot injection

Note:
The patient should be monitored for post-injection syndrome for at least three hours after each injection.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0927
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Risperidone orally disintegrating tablets

INITIAL APPLICATION - Acute situations
Applications from any relevant practitioner. Approvals valid for 6 weeks.

Prerequisites (tick boxes where appropriate)

☐ For a non-adherent patient on oral therapy with standard risperidone tablets or risperidone oral liquid
and
☐ The patient is under direct supervision for administration of medicine

INITIAL APPLICATION - Chronic situations
Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ The patient is unable to take standard risperidone tablets or oral liquid, or once stabilized refuses to take risperidone tablets or oral liquid
and
☐ The patient is under direct supervision for administration of medicine

RENEWAL

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ The patient is unable to take standard risperidone tablets or oral liquid, or once stabilized refuses to take risperidone tablets or oral liquid
and
☐ The patient is under direct supervision for administration of medicine

Note:
Risperdal Quicklets cost significantly more than risperidone tablets and should only be used where necessary.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0863
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Buspirone Hydrochloride

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ For use only as an anxiolytic

and

- ☐ Other agents are contraindicated or have failed

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1149
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Dexamphetamine Sulphate

INITIAL APPLICATION - ADHD in patients 5 or over
Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over

and

- ☐ Diagnosed according to DSM-IV or ICD 10 criteria

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

INITIAL APPLICATION - ADHD in patients under 5
Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age

and

- ☐ Diagnosed according to DSM-IV or ICD 10 criteria

INITIAL APPLICATION - Narcolepsy
Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

- ☐ The patient suffers from narcolepsy

Use next page for: Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1149
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Dexamphetamine Sulphate - continued

RENEWAL - ADHD in patients 5 or over

Current approval Number (if known):..

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

☐ Applicant is a paediatrician or psychiatrist

or

☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

RENEWAL - ADHD in patients under 5

Current approval Number (if known):..

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

RENEWAL - Narcolepsy

Current approval Number (if known):..

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1150
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR)

INITIAL APPLICATION - ADHD in patients 5 or over
Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients aged 5 years or over

and

☐ Diagnosed according to DSM-IV or ICD 10 criteria

and

☐ Applicant is a paediatrician or psychiatrist

or

☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

INITIAL APPLICATION - ADHD in patients under 5
Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ ADHD (Attention Deficit and Hyperactivity Disorder) patients under 5 years of age

and

☐ Diagnosed according to DSM-IV or ICD 10 criteria

INITIAL APPLICATION - Narcolepsy
Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

☐ The patient suffers from narcolepsy

Use next page for: Renewal - ADHD in patients 5 or over, Renewal - ADHD in patients under 5 and Renewal - Narcolepsy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1150
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR) - continued

RENEWAL - ADHD in patients 5 or over

Current approval Number (if known):..

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

RENEWAL - ADHD in patients under 5

Current approval Number (if known):..

Applications only from a paediatrician or psychiatrist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

RENEWAL - Narcolepsy

Current approval Number (if known):..

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1151
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA)

INITIAL APPLICATION
Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

- ☐ ADHD (Attention Deficit and Hyperactivity Disorder)

and

- ☐ Diagnosed according to DSM-IV or ICD 10 criteria

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

and

- ☐ Patient is taking a currently subsidised formulation of methylphenidate hydrochloride (immediate-release or sustained-release) which has not been effective due to significant administration and/or compliance difficulties

or

- ☐ There is significant concern regarding the risk of diversion or abuse of immediate-release methylphenidate hydrochloride

RENEWAL
Current approval Number (if known):..

Applications only from a paediatrician, psychiatrist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

- ☐ Applicant is a paediatrician or psychiatrist

or

- ☐ Applicant is a medical practitioner and confirms that a relevant specialist has been consulted within the last 2 years and has recommended treatment for the patient

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0951
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Atomoxetine

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

Prerequisites (tick boxes where appropriate)

❑ Patient has ADHD (Attention Deficit and Hyperactivity Disorder) diagnosed according to DSM-IV or ICD 10 criteria
and
❑ Once-daily dosing
and
- ❑ Treatment with a subsidised formulation of a stimulant has resulted in the development or worsening of serious adverse reactions or where the combination of subsidised stimulant treatment with another agent would pose an unacceptable medical risk
or
- ❑ Treatment with a subsidised formulation of a stimulant has resulted in worsening of co-morbid substance abuse or there is a significant risk of diversion with subsidised stimulant therapy
or
- ❑ An effective dose of a subsidised formulation of a stimulant has been trialled and has been discontinued because of inadequate clinical response

and
❑ The patient will not be receiving treatment with atomoxetine in combination with a subsidised formulation of a stimulant, except for the purposes of transitioning from subsidised stimulant therapy to atomoxetine

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:
A "subsidised formulation of a stimulant" refers to currently subsidised methylphenidate hydrochloride tablet formulations (immediate-release, sustained-release and extended-release) or dexamphetamine sulphate tablets.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1126
June 2012

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: ....

Modavigil

INITIAL APPLICATION
Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick boxes where appropriate)

❏ The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy occurring almost daily for three months or more

and

❏ The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minutes and 2 or more sleep onset rapid eye movement periods

or

❏ The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations

and

❏ An effective dose of a subsidised formulation of methylphenidate or dexamphetamine has been trialled and discontinued because of intolerable side effects

or

❏ Methylphenidate and dexamphetamine are contraindicated

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

Applications only from a neurologist or respiratory specialist. Approvals valid for 24 months.

Prerequisites (tick box where appropriate)

❏ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0909
June 2012

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: ....

Naltrexone

INITIAL APPLICATION
Applications from any medical practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- ☐ Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence

and

- ☐ Applicant works in or with a community Alcohol and Drug Service contracted to one of the District Health Boards or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard

RENEWAL

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

Applications from any medical practitioner. Approvals valid for 3 months. The patient must have had no more than 1 prior approval in the last 12 months

Prerequisites (tick boxes where appropriate)

- ☐ Compliance with the medication (prescriber determined)

and

- ☐ Patient is still unstable and requires further treatment

  or

- ☐ Patient achieved significant improvement but requires further treatment

  or

- ☐ Patient is well controlled but requires maintenance therapy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1161
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Varenicline tartrate

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 5 months.

Prerequisites (tick boxes where appropriate)

☐ Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
and
☐ The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
and
- ☐ The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy
- **or**
- ☐ The patient has tried but failed to quit smoking using bupropion or nortriptyline

and
☐ The patient has not used funded varenicline in the last 12 months
and
☐ Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
and
☐ The patient is not pregnant
and
☐ The patient will not be prescribed more than 3 months' funded varenicline (see note)

RENEWAL
Current approval Number (if known):....................................
Applications from any relevant practitioner. Approvals valid for 5 months. The patient must have had no prior approvals in the last 12 months

Prerequisites (tick boxes where appropriate)

☐ Short-term therapy as an aid to achieving abstinence in a patient who has indicated that they are ready to cease smoking
and
☐ The patient is part of, or is about to enrol in, a comprehensive support and counselling smoking cessation programme, which includes prescriber or nurse monitoring
and
☐ The patient has not used funded varenicline in the last 12 months
and
☐ Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this
and
☐ The patient is not pregnant
and
☐ The patient will not be prescribed more than 3 months' funded varenicline (see note)

Note:
a maximum of 3 months' varenicline will be subsidised on each Special Authority approval.

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

Oncology Agents and Immunosuppressants

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0900
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Oxaliplatin

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has metastatic colorectal cancer

and

- ☐ To be used for first or second line use as part of a combination chemotherapy regimen

or

- ☐ The patient has stage III (Duke's C) colorectal* cancer

and

- ☐ Adjuvant oxaliplatin to be given in combination with a fluoropyrimidine (fluorouracil or capecitabine)

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient requires continued therapy

or

- ☐ The tumour has relapsed and requires re-treatment

Note:
Indications marked with * are Unapproved Indications, oxaliplatin is indicated for adjuvant treatment of stage III (Duke's C) colon cancer after complete resection of the primary tumour.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1049
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Capecitabine

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has advanced gastrointestinal malignancy

or

- [ ] The patient has metastatic breast cancer

or

- [ ] The patient has stage III (Duke's stage C) colorectal*# cancer and undergone surgery

or

- [ ] The patient has stage II (Dukes' stage B) colorectal* cancer and has undergone surgery

  and

  - [ ] The patient has stage T4 disease

    or

  - [ ] The patient has vascular invasion

    or

  - [ ] Fewer than 10 lymph nodes were examined at resection

or

- [ ] The patient has locally advanced (clinically or radiologically staged T3/T4: N0,1,2) rectal cancer

  and

- [ ] Surgery is planned

  and

- [ ] Capecitabine to be given prior to surgery (neoadjuvant)

  and

- [ ] Capecitabine to be given at a maximum dose of 825 mg/m² twice daily in combination with radiation therapy for a maximum of 6 weeks

or

- [ ] The patient has poor venous access or needle phobia*

  and

- [ ] The patient requires a substitute for single agent fluoropyrimidine*

Note:
Indications marked with * are Unapproved Indications, # capecitabine is approved for stage III (Duke's stage C) colon cancer.

Use next page for: Renewal

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1049
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Capecitabine - continued

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient requires continued therapy

or

- ☐ The tumour has relapsed and requires re-treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0878
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Irinotecan

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has metastatic colorectal cancer

and

- [ ] To be used for first or second line use as part of a combination chemotherapy regimen

or

- [ ] As single agent chemotherapy in fluropyrimidine-relapsed disease

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient requires continued therapy

or

- [ ] The tumour has relapsed and requires re-treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1087
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Gemcitabine hydrochloride

INITIAL APPLICATION - Hodgkin's Disease
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has Hodgkin's Disease*

and

- ☐ Disease has failed to respond to second line salvage chemotherapy treatment

  or

- ☐ Disease has relapsed following transplant

  or

- ☐ The patient is unsuitable for, or intolerant to, second-line salvage chemotherapy or high dose chemotherapy and transplant

and

☐ Gemcitabine to be given for a maximum of 6 treatment cycles

Note:
Indications marked with a * are Unapproved Indications.

INITIAL APPLICATION - T-Cell Lymphoma
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has T-cell Lymphoma*

and

☐ Gemcitabine to be given for a maximum of 6 treatment cycles

Note:
Indications marked with a * are Unapproved Indications.

INITIAL APPLICATION - Cholangiocarcinoma
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has locally advanced or metastatic, cholangiocarcinoma*

and

☐ Gemcitabine to be given for a maximum of 8 treatment cycles

Note:
Cholangiocarcinoma encompasses epithelial tumours of the hepatobiliary tree, including tumours of bile ducts, ampulla of vater and gallbladder.

Indications marked with a * are Unapproved Indications.

Use next page for: Initial application - Pancreatic Cancer, Renewal - Pancreatic Cancer, Initial application - Other indications and Renewal - Other indications

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1087
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Gemcitabine hydrochloride - continued

INITIAL APPLICATION - Pancreatic Cancer
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has macroscopically resected (R0) pancreatic carcinoma*

and

- [ ] Adjuvant gemcitabine to be administered for a maximum of 6 cycles

or

- [ ] The patient has advanced pancreatic carcinoma

and

- [ ] The patient is gemcitabine treatment naive

Note:
Indications marked with a * are Unapproved Indications.

RENEWAL - Pancreatic Cancer

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has received gemcitabine for advanced pancreatic carcinoma

and

- [ ] The patient has not received gemcitabine for adjuvant treatment pancreatic carcinoma

and

- [ ] The patient requires continued therapy

Use next page for: Initial application - Other indications and Renewal - Other indications

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Gemcitabine hydrochloride - continued

INITIAL APPLICATION - Other indications
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ 1 The patient has non small cell lung carcinoma (stage IIIa, or above)
or
☐ The patient has advanced malignant mesothelioma
or
☐ The patient has ovarian, fallopian tube* or primary peritoneal carcinoma*
or
☐ The patient has advanced transitional cell carcinoma of the urothelial tract (locally advanced or metastatic)

Note:
Indications marked with a * are Unapproved Indications.

RENEWAL - Other indications
Current approval Number (if known):..........

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient requires continued therapy
or
☐ The tumour has relapsed and requires re-treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1013
June 2012

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: ....

Vinorelbine

INITIAL APPLICATION - Hodgkin's Disease
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has Hodgkin's Disease*
and
- ☐ Disease has failed to respond to second-line salvage chemotherapy treatment
  or
- ☐ Disease has relapsed following transplant
  or
- ☐ The patient is unsuitable for, or intolerant to, second-line salvage chemotherapy or high dose chemotherapy and transplant

and
☐ Vinorelbine to be given for a maximum of 6 treatment cycles

INITIAL APPLICATION - T-Cell Lymphoma
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has T-cell Lymphoma*
and
☐ Vinorelbine to be given for a maximum of 6 treatment cycles

INITIAL APPLICATION - Other indications
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has metastatic breast cancer
or
☐ The patient has non-small cell lung cancer (stage IIIa, or above)
or
- ☐ The patient has stage IB-IIIA non-small cell lung cancer
  and
- ☐ Vinorelbine is to be given as adjuvant treatment in combination with cisplatin
  and
- ☐ The patient has good performance status (WHO/ECOG grade 0-1)

Use next page for: Renewal - Other indications

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1013
June 2012

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: ....

Vinorelbine - continued

RENEWAL - Other indications

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

❏ The patient requires continued therapy

or

❏ The tumour has relapsed and requires re-treatment

Note:
Indications marked with a * are Unapproved Indications.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0879
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Anagrelide Hydrochloride

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has primary thrombocythaemia

and

☐ is at high risk (previous thromboembolic disease, bleeding or platelet count >1500/ml)

or

☐ is intolerant or refractory to hydroxyurea or interferon

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

Note:
It is recommended that treatment with anagrelide be initiated only on the recommendation of a haematologist.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1124
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Thalidomide

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

❑ The patient has multiple myeloma
or
❑ The patient has systemic AL amyloidosis*

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has obtained a response from treatment during the initial approval period

Note:
Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.
Indication marked with * is an Unapproved Indication.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1063
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Temozolomide

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid for 10 months.

Prerequisites (tick boxes where appropriate)

☐ Patient has newly diagnosed glioblastoma multiforme
or
☐ Patient has newly diagnosed anaplastic astrocytoma*

and
☐ Temozolomide is to be (or has been) given concomitantly with radiotherapy
and
☐ Following concomitant treatment temozolomide is to be used for a maximum of six cycles of 5 days treatment, at a maximum dose of 200 mg/m²

Note:

Indication marked with a * is an Unapproved Indication. Temozolomide is not subsidised for the treatment of relapsed glioblastoma multiforme. Reapplications will not be approved.

Studies of temozolomide show that its benefit is predominantly in those patients with a good performance status (WHO grade 0 or 1 or Karnofsky score >80), and in patients who have had at least a partial resection of the tumour.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1127
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

bortezomib

INITIAL APPLICATION - Treatment naive multiple myeloma/amyloidosis
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has treatment-naive symptomatic multiple myeloma

or

- [ ] The patient has treatment-naive symptomatic systemic AL amyloidosis *

and

- [ ] Maximum of 9 treatment cycles

Note:
Indications marked with * are Unapproved Indications.

INITIAL APPLICATION - Relapsed/refractory multiple myeloma/amyloidosis
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has relapsed or refractory multiple myeloma

or

- [ ] The patient has relapsed or refractory systemic AL amyloidosis *

and

- [ ] The patient has received only one prior front line chemotherapy for multiple myeloma or amyloidosis

and

- [ ] The patient has not had prior publicly funded treatment with bortezomib

and

- [ ] Maximum of 4 treatment cycles

Note:
Indications marked with * are Unapproved Indications.

RENEWAL - Relapsed/refractory multiple myeloma/amyloidosis

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 8 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient's disease obtained at least a partial response from treatment with bortezomib at the completion of cycle 4

and

- [ ] Maximum of 4 further treatment cycles (making a total maximum of 8 consecutive treatment cycles)

Note:
Responding relapsed/refractory multiple myeloma patients should receive no more than 2 additional cycles of treatment beyond the cycle at

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1127
June 2012

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: ....

which a confirmed complete response was first achieved. A line of therapy is considered to comprise either:

a) a known therapeutic chemotherapy regimen and supportive treatments; or
b) a transplant induction chemotherapy regimen, stem cell transplantation and supportive treatments.

Refer to datasheet for recommended dosage and number of doses of bortezomib per treatment cycle.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1044
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Erlotinib

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

Prerequisites (tick boxes where appropriate)

❑ Patient has advanced, unresectable, Non Small Cell Lung Cancer (NSCLC)
and
❑ Patient has documented disease progression following treatment with first line platinum based chemotherapy
and
❑ Erlotinib is to be given for a maximum of 3 months

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

❑ radiological assessment (preferably including CT scan) indicates NSCLC has not progressed

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1200
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Sunitinib

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has metastatic renal cell carcinoma

and

- [ ] The patient is treatment naive

  or
- [ ] The patient has only received prior cytokine treatment

  or
- [ ] The patient has only received prior treatment with an investigational agent within the confines of a bona fide clinical trial which has Ethics Committee approval

  or
  - [ ] The patient has discontinued pazopanib within 3 months of starting treatment due to intolerance

    and
  - [ ] The cancer did not progress whilst on pazopanib

and

- [ ] The patient has good performance status (WHO/ECOG grade 0-2)

and

- [ ] The disease is of predominant clear cell histology

and

The patient has intermediate or poor prognosis defined as:

- [ ] Lactate dehydrogenase level > 1.5 times upper limit of normal

  or
- [ ] Haemoglobin level < lower limit of normal

  or
- [ ] Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

  or
- [ ] Interval of < 1 year from original diagnosis to the start of systemic therapy

  or
- [ ] Karnofsky performance score of ≤ 70

  or
- [ ] ≥ 2 sites of organ metastasis

and

- [ ] Sunitinib to be used for a maximum of 2 cycles

Use next page for: Renewal

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

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Sunitinib - continued

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- ☐ No evidence of disease progression

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

Note:

Sunitinib treatment should be stopped if disease progresses.

Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1190
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Pazopanib

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has metastatic renal cell carcinoma

and

- [ ] The patient is treatment naive

  or

- [ ] The patient has only received prior cytokine treatment

  or

  - [ ] The patient has discontinued sunitinib within 3 months of starting treatment due to intolerance

    and

  - [ ] The cancer did not progress whilst on sunitinib

and

- [ ] The patient has good performance status (WHO/ECOG grade 0-2)

and

- [ ] The disease is of predominant clear cell histology

and

The patient has intermediate or poor prognosis defined as:

- [ ] Lactate dehydrogenase level > 1.5 times upper limit of normal

  or

- [ ] Haemoglobin level < lower limit of normal

  or

- [ ] Corrected serum calcium level > 10 mg/dL (2.5 mmol/L)

  or

- [ ] Interval of < 1 year from original diagnosis to the start of systemic therapy

  or

- [ ] Karnofsky performance score of ≤ 70

  or

- [ ] ≥ 2 sites of organ metastasis

and

- [ ] Pazopanib to be used for a maximum of 3 months

Use next page for: Renewal

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1190
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Pazopanib - continued

RENEWAL

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

- ☐ No evidence of disease progression

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

Note:

Pazopanib treatment should be stopped if disease progresses.

Poor prognosis patients are defined as having at least 3 of criteria 5.1-5.6. Intermediate prognosis patients are defined as having 1 or 2 of criteria 5.1-5.6.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1191
June 2012

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: ....

Lapatinib

INITIAL APPLICATION - metastatic breast cancer
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ The patient has not previously received trastuzumab treatment for HER 2 positive metastatic breast cancer

and

- ☐ Lapatinib not to be given in combination with trastuzumab

and

- ☐ Lapatinib to be discontinued at disease progression

or

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ The patient started trastuzumab for metastatic breast cancer but discontinued trastuzumab within 3 months of starting treatment due to intolerance

and

- ☐ The cancer did not progress whilst on trastuzumab

and

- ☐ Lapatinib not to be given in combination with trastuzumab

and

- ☐ Lapatinib to be discontinued at disease progression

RENEWAL - metastatic breast cancer

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ The cancer has not progressed at any time point during the previous 12 months whilst on lapatinib

and

- ☐ Lapatinib not to be given in combination with trastuzumab

and

- ☐ Lapatinib to be discontinued at disease progression

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1016
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Octreotide (somatostatin analogue)

INITIAL APPLICATION - Malignant Bowel Obstruction
Applications from any relevant practitioner. Approvals valid for 2 months.

Prerequisites (tick boxes where appropriate)

❑ The patient has nausea* and vomiting* due to malignant bowel obstruction*
and
❑ Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has failed
and
❑ Octreotide to be given at a maximum dose 1500 µg daily for up to 4 weeks

Note:
Indications marked with * are Unapproved Indications.

RENEWAL - Malignant Bowel Obstruction

Current approval Number (if known):..

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

Prerequisites (tick box where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

INITIAL APPLICATION - Acromegaly
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

❑ The patient has acromegaly
and
- ❑ Treatment with surgery, radiotherapy and a dopamine agonist has failed
- **or**
- ❑ Treatment with octreotide is for an interim period while awaiting the effects of radiotherapy and a dopamine agonist has failed
- **or**
- ❑ The patient is unwilling, or unable, to undergo surgery and/or radiotherapy

Use next page for: Renewal - Acromegaly, Initial application - Other Indications and Renewal - Other Indications

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

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Octreotide (somatostatin analogue) - continued

RENEWAL - Acromegaly

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ IGF1 levels have decreased since starting octreotide
and
☐ The treatment remains appropriate and the patient is benefiting from treatment

Note:
In patients with Acromegaly octreotide treatment should be discontinued if IGF1 levels have not decreased after 3 months treatment. In patients treated with radiotherapy octreotide treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Octreotide treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following octreotide treatment withdrawal for at least 4 weeks

INITIAL APPLICATION - Other Indications
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
or
- ☐ Gastrinoma
  and
  - ☐ Patient has failed surgery
    or
  - ☐ Patient in metastatic disease after H2 antagonists (or proton pump inhibitors) have failed

or
- ☐ Insulinomas
  and
  ☐ Surgery is contraindicated or has failed

or
☐ For pre-operative control of hypoglycaemia and for maintenance therapy
or
- ☐ Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
  and
  ☐ Disabling symptoms not controlled by maximal medical therapy

Note:
The use of octreotide in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded as a Special Authority item

Use next page for: Renewal - Other Indications

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1016
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Octreotide (somatostatin analogue) - continued

RENEWAL - Other Indications

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0941
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Bicalutamide

INITIAL APPLICATION
Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

❑ The patient has advanced prostate cancer

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1041
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Mycophenolate mofetil

INITIAL APPLICATION
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ Transplant recipient

or

Patients with diseases where

- ☐ Steroids and azathioprine have been trialled and discontinued because of unacceptable side effects or inadequate clinical response

and

Patients with diseases where

- ☐ Cyclophosphamide has been trialled and discontinued because of unacceptable side effects or inadequate clinical response

or

- ☐ Cyclophosphamide treatment is contraindicated

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1152
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Rituximab

INITIAL APPLICATION - Post-transplant
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has B-cell post-transplant lymphoproliferative disorder*

and

- ☐ To be used for a maximum of 8 treatment cycles

Note:
Indications marked with * are Unapproved Indications.

INITIAL APPLICATION - Indolent, Low-grade lymphomas
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has indolent low grade NHL with relapsed disease following prior chemotherapy

and

- ☐ To be used for a maximum of 6 treatment cycles

or

- ☐ The patient has indolent, low grade lymphoma requiring first-line systemic chemotherapy

and

- ☐ To be used for a maximum of 6 treatment cycles

Note:
'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia.

Use next page for: Initial application - Aggressive CD20 positive NHL, Initial application - Chronic Lymphocytic Leukaemia, Renewal - Post-transplant, Renewal - Indolent, Low-grade lymphomas and Renewal - Aggressive CD20 positive NHL

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

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Rituximab - continued

INITIAL APPLICATION - Aggressive CD20 positive NHL
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has treatment naive aggressive CD20 positive NHL

and

- [ ] To be used with a multi-agent chemotherapy regimen given with curative intent

and

- [ ] To be used for a maximum of 8 treatment cycles

or

- [ ] The patient has aggressive CD20 positive NHL with relapsed disease following prior chemotherapy

and

- [ ] To be used for a maximum of 6 treatment cycles

Note:
'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

Use next page for: Initial application - Chronic Lymphocytic Leukaemia, Renewal - Post-transplant, Renewal - Indolent, Low-grade lymphomas and Renewal - Aggressive CD20 positive NHL

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1152
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Rituximab - continued

INITIAL APPLICATION - Chronic Lymphocytic Leukaemia
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has progressive Binet stage A, B or C chronic lymphocytic leukaemia (CLL) requiring treatment

and

- [ ] The patient is rituximab treatment naive

and

- [ ] The patient is chemotherapy treatment naive

  or

  - [ ] The patient's disease has relapsed following no more than three prior lines of chemotherapy treatment

    and

  - [ ] The patient has had a treatment-free interval of 12 months or more if previously treated with fludarabine and cyclophosphamide chemotherapy

and

- [ ] The patient has good performance status

and

- [ ] The patient has good renal function (creatinine clearance ≥ 30 ml/min)

and

- [ ] The patient does not have chromosome 17p deletion CLL

and

- [ ] Rituximab to be administered in combination with fludarabine and cyclophosphamide for a maximum of 6 treatment cycles

and

- [ ] It is planned that the patient receives full dose fludarabine and cyclophosphamide (orally or dose equivalent intravenous administration)

Note:
'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma. A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with rituximab is expected to improve symptoms and improve ECOG score to <2.

RENEWAL - Post-transplant

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

- [ ] The patient has had a rituximab treatment-free interval of 12 months or more

and

- [ ] The patient has B-cell post-transplant lymphoproliferative disorder*

and

- [ ] To be used for no more than 6 treatment cycles

Note:

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1152
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Indications marked with * are Unapproved Indications.

Use next page for: Renewal - Indolent, Low-grade lymphomas and Renewal - Aggressive CD20 positive NHL

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1152
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Rituximab - continued

RENEWAL - Indolent, Low-grade lymphomas

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 9 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has had a rituximab treatment-free interval of 12 months or more
and
☐ The patient has indolent, low-grade NHL with relapsed disease following prior chemotherapy
and
☐ To be used for no more than 6 treatment cycles

Note:
'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia.

RENEWAL - Aggressive CD20 positive NHL

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

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has had a rituximab treatment-free interval of 12 months or more
and
☐ The patient has relapsed refractory/aggressive CD20 positive NHL
and
☐ To be used with a multi-agent chemotherapy regimen given with curative intent
and
☐ To be used for a maximum of 4 treatment cycles

Note:
'Aggressive CD20 positive NHL' includes large B-cell lymphoma and Burkitt's lymphoma/leukaemia

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1192
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Trastuzumab

INITIAL APPLICATION - metastatic breast cancer
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and
☐ The patient has not previously received lapatinib treatment for HER 2 positive metastatic breast cancer
and
☐ Trastuzumab not to be given in combination with lapatinib
and
☐ Trastuzumab to be discontinued at disease progression

or

☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and
☐ The patient started lapatinib treatment for metastatic breast cancer but discontinued lapatinib within 3 months of starting treatment due to intolerance
and
☐ The cancer did not progress whilst on lapatinib
and
☐ Trastuzumab not to be given in combination with lapatinib
and
☐ Trastuzumab to be discontinued at disease progression

RENEWAL - metastatic breast cancer

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)
and
☐ The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
and
☐ Trastuzumab not to be given in combination with lapatinib
and
☐ Trastuzumab to be discontinued at disease progression

Use next page for: Initial application - early breast cancer* and Renewal - early breast cancer*

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1192
June 2012

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: ....

Trastuzumab - continued

INITIAL APPLICATION - early breast cancer*
Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has early breast cancer expressing HER 2 IHC 3+ or ISH + (including FISH or other current technology)
and
☐ Maximum cumulative dose of 106 mg/kg (12 months' treatment)
and
- ☐ 9 weeks' concurrent treatment with adjuvant chemotherapy is planned
  or
- ☐ 12 months' concurrent treatment with adjuvant chemotherapy is planned
  or
- ☐ 12 months' sequential treatment following adjuvant chemotherapy is planned
  or
- ☐ Other treatment regimen, in association with adjuvant chemotherapy, is planned

Use next page for: Renewal - early breast cancer*

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1192
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Trastuzumab - continued

RENEWAL - early breast cancer*

Current approval Number (if known):..

Applications only from a relevant specialist or any other medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.

Prerequisites (tick boxes where appropriate)

- ☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

and

- ☐ The patient received prior adjuvant trastuzumab treatment for early breast cancer

and

- ☐ The patient has not previously received lapatinib treatment for metastatic breast cancer
  and
- ☐ Trastuzumab not to be given in combination with lapatinib
  and
- ☐ Trastuzumab to be discontinued at disease progression

or

- ☐ The patient started lapatinib treatment for metastatic breast cancer but discontinued lapatinib within 3 months of starting treatment due to intolerance
  and
- ☐ The cancer did not progress whilst on lapatinib
  and
- ☐ Trastuzumab not to be given in combination with lapatinib
  and
- ☐ Trastuzumab to be discontinued at disease progression

or

- ☐ The cancer has not progressed at any time point during the previous 12 months whilst on trastuzumab
  and
- ☐ Trastuzumab not to be given in combination with lapatinib
  and
- ☐ Trastuzumab to be discontinued at disease progression

Note:
* For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0669
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Tacrolimus

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

- ☐ The patient is an organ transplant recipient

Note:
Subsidy applies for either primary or rescue therapy.

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0866
June 2012

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: ....

Sirolimus (Rapamune)

INITIAL APPLICATION
Applications from any medical practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick box where appropriate)

☐ The drug is to be used for rescue therapy for an organ transplant recipient

Note:
Rescue therapy defined as unresponsive to calcineurin inhibitor treatment as defined by refractory rejection; or intolerant to calcineurin inhibitor treatment due to any of the following:

- GFR<30 ml/min; or
- Rapidly progressive transplant vasculopathy; or
- Rapidly progressive obstructive bronchiolitis; or
- HUS or TTP; or
- Leukoencepthalopathy; or
- Significant malignant disease

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

Respiratory System and Allergies

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0053
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Bee Venom Allergy Treatment; Wasp venom allergy treatment (Circle one)

INITIAL APPLICATION
Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

☐ RAST or skin test positive

and

☐ Patient has had severe generalised reaction to the sensitising agent

RENEWAL

Current approval Number (if known):...

Applications only from a relevant specialist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1179
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

- ☐ Patient is a child under the age of 12

and

- ☐ Has been treated with inhaled corticosteroids of at least 400 µg per day beclomethasone or budesonide, or 200 µg per day fluticasone

and

- ☐ The prescriber considers that the patient would receive additional clinical benefit from switching to a combination product

or

- ☐ Patient is over the age of 12

and

- ☐ Has been treated with inhaled corticosteroids of at least 800 µg per day beclomethasone or budesonide, or 500 µg per day fluticasone

and

- ☐ The prescriber considers that the patient would receive additional clinical benefit from switching to a combination product

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

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1193
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Tiotropium Bromide

INITIAL APPLICATION
Applications only from a general practitioner or relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ To be used for the long-term maintenance treatment of bronchospasm and dyspnoea associated with COPD

and

☐ In addition to standard treatment, the patient has trialled a short acting bronchodilator of at least 40 µg ipratropium q.i.d for one month

and

The patient's breathlessness according to the Medical Research Council (UK) dyspnoea scale is:

☐ Grade 4 (stops for breath after walking about 100 meters or after a few minutes on the level)

or

☐ Grade 5 (too breathless to leave the house, or breathless when dressing or undressing)

and

Applicant must state recent measurement of:

Actual FEV_1 (litres): ....

and

Predicted FEV_1 (litres): ....

and

Actual FEV_1 as a % of predicted (must be below 60%): ....

and

☐ Patient is not a smoker (for reporting purposes only)

or

☐ Patient is a smoker and has been offered smoking cessation counselling

and

☐ The patient has been offered annual influenza immunisation

RENEWAL

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

Applications only from a general practitioner or relevant specialist. Approvals valid for 2 years.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

☐ Patient is compliant with the medication

and

☐ Patient has experienced improved COPD symptom control (prescriber determined)

and

Applicant must state recent measurement of:

Actual FEV_1 (litres): ....

and

Predicted FEV_1 (litres): ....

and

Actual FEV_1 as a % of predicted: ....

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

Sensory Organs

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA0895
June 2012

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: ....

Pilocarpine – Eye drops 2% single dose

INITIAL APPLICATION
Applications from any relevant practitioner. Approvals valid for 2 years.

Prerequisites (tick boxes where appropriate)

❑ Patient has to use an unpreserved solution due to an allergy to the preservative

or

❑ Patient wears soft contact lenses

Note:
Minims for a general practice are considered to be “tools of trade” and are not approved as special authority items.

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

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

Special Foods

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1090
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Carbohydrate (Moducal; Polycal)

INITIAL APPLICATION - Cystic fibrosis or renal failure
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

☐ cystic fibrosis
or
☐ chronic renal failure or continuous ambulatory peritoneal dialysis (CAPD) patient

INITIAL APPLICATION - Indications other than cystic fibrosis or renal failure
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ cancer in children
or
☐ cancers affecting alimentary tract where there are malabsorption problems in patients over the age of 20 years
or
☐ failure to thrive
or
☐ growth deficiency
or
☐ bronchopulmonary dysplasia
or
☐ premature and post premature infant
or
☐ inborn errors of metabolism

Use next page for: Renewal - Cystic fibrosis or renal failure and Renewal - Indications other than cystic fibrosis or renal failure

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Carbohydrate (Moducal; Polycal) - continued

RENEWAL - Cystic fibrosis or renal failure

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian,relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

RENEWAL - Indications other than cystic fibrosis or renal failure

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1091
June 2012

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: ....

Carbohydrate and Fat (Duocal Super Soluble Powder)

INITIAL APPLICATION - Cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

☐ infant aged four years or under
and
☐ cystic fibrosis

INITIAL APPLICATION - Indications other than cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ infant aged four years or under
and
- ☐ cancer in children
- **or**
- ☐ failure to thrive
- **or**
- ☐ growth deficiency
- **or**
- ☐ bronchopulmonary dysplasia
- **or**
- ☐ premature and post premature infants

Use next page for: Renewal - Cystic fibrosis and Renewal - Indications other than cystic fibrosis
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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1091
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Carbohydrate and Fat (Duocal Super Soluble Powder) - continued

RENEWAL - Cystic fibrosis

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

RENEWAL - Indications other than cystic fibrosis

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1092
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Fat (Calogen; Liquigen; MCT oil (Nutricia))

INITIAL APPLICATION - Inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

- ☐ The patient has inborn errors of metabolism

INITIAL APPLICATION - Indications other than inborn errors of metabolism
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ failure to thrive where other high calorie products are inappropriate or inadequate
or
☐ growth deficiency
or
☐ bronchopulmonary dysplasia
or
☐ fat malabsorption
or
☐ lymphangiectasia
or
☐ short bowel syndrome
or
☐ infants with necrotising enterocolitis
or
☐ biliary atresia

Use next page for: Renewal - Inborn errors of metabolism and Renewal - Indications other than inborn errors of metabolism

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1092
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Fat (Calogen; Liquigen; MCT oil (Nutricia)) - continued

RENEWAL - Inborn errors of metabolism

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

RENEWAL - Indications other than inborn errors of metabolism

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1093
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Protein (Protifar; Promod; Resource Beneprotein)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ protein losing enteropathy

or

- ☐ high protein needs (eg burns)

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1094
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

CORD Products (Pulmocare)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

- ❑ The patient has CORD and hypercapnia

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

- ❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1095
June 2012

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: ....

Diabetic products (Diason RTH; Glucerna Select RTH; Diasip; Glucerna Select; Resource Diabetic)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

❑ The patient is a type I or and II diabetic who is suffering weight loss and malnutrition that requires nutritional support

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted: ....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1096
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Fat Modified Products (Monogen)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Patient has metabolic disorders of fat metabolism
or
☐ Patient has chylothorax

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1097
June 2012

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: ....

High Protein Products (Fortimel Regular)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Anorexia and weight loss
and
- ☐ decompensating liver disease without encephalopathy
- **or**
- ☐ protein losing gastro-enteropathy

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted: ....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1098
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Paediatric Product For Children Awaiting Liver Transplant (Generaid Plus)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

❑ The patient is a child (up to 18 years) who is awaiting liver transplant

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1099
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Paediatric Product For Children With Chronic Renal Failure (Kindergen)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

❑ The patient is a child (up to 18 years) with chronic renal failure

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1100
June 2012

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: ....

Paediatric Products (Nutrini; Pediasure; Fortini)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Infant aged one to eight years

and

- ☐ any condition causing malabsorption

  or

- ☐ failure to thrive

  or

- ☐ increased nutritional requirements

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1101
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Renal Products (Nepro; NovaSource Renal; Renilon 7.5)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

❏ The patient has acute or chronic renal failure

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❏ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1102
June 2012

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: ....

Specialised And Elemental Products (Alitraq; Elemental 028 Extra; Peptisorb; Vital HN; Vivonex TEN)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ malabsorption

or

- ☐ short bowel syndrome

or

- ☐ enterocutaneous fistulas

or

- ☐ pancreatitis

Note:

Each of these products is highly specialised and would be prescribed only by an expert for a specific disorder. The alternative is hospitalisation.

Elemental 028 Extra is more expensive than other products listed in this section and should only be used where the alternatives have been tried first and/or are unsuitable.

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1103
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Products for Undialysed End Stage Renal Failure (Suplena)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box where appropriate)

❑ The patient has undialysed end stage renal failure

Note:
Where possible, the requirements for oral supplementation should be established in conjunction with assessment by a dietitian.

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1196
June 2012

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: ....

Paediatric enteral feed with fibre 0.75 kcal/ml (Nutrini Low Energy Multi Fibre)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Child aged one to eight years
and
☐ The child has a low energy requirement but normal protein and micronutrient requirements

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment
and
General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1104
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen)

INITIAL APPLICATION - Children
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ The patient is under 18 years of age

and

- ☐ The patient has a condition causing malabsorption

  or

- ☐ The patient has failure to thrive

  or

- ☐ The patient has increased nutritional requirements

and

- ☐ Nutrition goal has been set (eg reach a specific weight or BMI)

RENEWAL - Children

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ The patient is under 18 years of age

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

- ☐ A nutrition goal has been set (eg reach a specific weight or BMI)

Use next page for: Initial application - Adults, Renewal - Adults, Initial application - Adults transitioning from hospital Discretionary Community Supply, Initial application - Specific medical condition, Renewal - Specific medical condition, Initial application - Chronic disease OR tube feeding and Renewal - Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1104
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen) - continued

INITIAL APPLICATION - Adults
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 months.

Prerequisites (tick boxes where appropriate)

Patient is Malnourished
- ☐ Patient has a body mass index (BMI) of less than 18.5 kg/m2

or
- ☐ Patient has unintentional weight loss greater than 10% within the last 3-6 months

or
- ☐ Patient has a BMI of less than 20 kg/m2 and unintentional weight loss greater than 5% within the last 3-6 months

and

Patient has not responded to first-line dietary measures over a 4 week period by:
- ☐ Increasing their food intake frequency (eg snacks between meals)

or
- ☐ Using high-energy foods (e.g. milkshakes, full fat milk, butter, cream, cheese, sugar etc)

or
- ☐ Using over the counter supplements (e.g. Complan)

and
- ☐ A nutrition goal has been set (e.g. to reach a specific weight or BMI)

RENEWAL - Adults
Current approval Number (if known):..........

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ A nutrition goal has been set (eg reach a specific weight or BMI)

and

Patient is Malnourished
- ☐ Patient has a body mass index (BMI) of less than 18.5 kg/m2

or
- ☐ Patient has unintentional weight loss greater than 10% within the last 3-6 months

or
- ☐ Patient has a BMI of less than 20 kg/m2 and unintentional weight loss greater than 5% within the last 3-6 months

Use next page for: Initial application - Adults transitioning from hospital Discretionary Community Supply, Initial application - Specific medical condition, Renewal - Specific medical condition, Initial application - Chronic disease OR tube feeding and Renewal - Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1104
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen) - continued

INITIAL APPLICATION - Adults transitioning from hospital Discretionary Community Supply
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

☐ The patient has had up to a 30 day supply of a 1.0 or a 1.5 kcal/ml Standard Oral Supplement

and

☐ A nutrition goal has been set (eg reach a specific weight or BMI)

and

Patient is Malnourished

☐ Patient has a body mass index (BMI) of less than 18.5 kg/m2

or

☐ Patient has unintentional weight loss greater than 10% within the last 3-6 months

or

☐ Patient has a BMI of less than 20 kg/m2 and unintentional weight loss greater than 5% within the last 3-6 months

INITIAL APPLICATION - Specific medical condition
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ Is being feed via a nasogastric tube or a nasogastric tube is to be inserted for feeding

or

☐ Malignancy and is considered likely to develop malnutrition as a result

or

☐ Is undergoing a bone marrow transplant

or

☐ Tempomandibular surgery

Use next page for: Renewal - Specific medical condition, Initial application - Chronic disease OR tube feeding and Renewal - Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1104
June 2012

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: ....

Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen) - continued

RENEWAL - Specific medical condition

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

- ☐ Is being fed via a nasogastric tube

or

- ☐ Malignancy and is considered likely to develop malnutrition as a result

or

- ☐ Has undergone a bone marrow transplant

or

- ☐ Tempomandibular surgery

INITIAL APPLICATION - Chronic disease OR tube feeding
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)

or

- ☐ Cystic Fibrosis

or

- ☐ Liver disease

or

- ☐ Chronic Renal failure

or

- ☐ Inflammatory bowel disease

or

- ☐ Chronic obstructive pulmonary disease with hypercapnia

or

- ☐ Short bowel syndrome

or

- ☐ Bowel fistula

or

- ☐ Severe chronic neurological conditions

Use next page for: Renewal - Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1104
June 2012

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: ....

Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen) - continued

RENEWAL - Chronic disease OR tube feeding for patients who have previously been funded under Special Authority forms SA0702 or SA0583

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ Is being fed via a tube or a tube is to be inserted for the purpose of feeding (not nasogastric tube - refer to specific medical condition criteria)

or

- ☐ Cystic Fibrosis

or

- ☐ Liver disease

or

- ☐ Chronic Renal failure

or

- ☐ Inflammatory bowel disease

or

- ☐ Chronic obstructive pulmonary disease with hypercapnia

or

- ☐ Short bowel syndrome

or

- ☐ Bowel fistula

or

- ☐ Severe chronic neurological conditions

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1195
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adult Products High Calorie (Two Cal HN; Nutrison Concentrated)

INITIAL APPLICATION - Cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick boxes where appropriate)

☐ Cystic fibrosis
and
☐ other lower calorie products have been tried
and
☐ patient has substantially increased metabolic requirements

INITIAL APPLICATION - Indications other than cystic fibrosis
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick boxes where appropriate)

☐ any condition causing malabsorption
or
☐ failure to thrive
or
☐ increased nutritional requirements
or
☐ fluid restricted

and
☐ other lower calorie products have been tried
and
☐ patient has substantially increased metabolic requirements or is fluid restricted

Use next page for: Renewal - Cystic fibrosis and Renewal - Indications other than cystic fibrosis
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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1195
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Adult Products High Calorie (Two Cal HN; Nutrison Concentrated) - continued

RENEWAL - Cystic fibrosis

Current approval Number (if known):...

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

RENEWAL - Indications other than cystic fibrosis

Current approval Number (if known):...

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1106
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Food Thickeners (Karicare Food Thickener)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

☐ The patient has motor neurone disease with swallowing disorder

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

☐ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1107
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Gluten Free Foods (Bakels Gluten Free Health Bread Mix; Horleys Bread Mix; Horleys Flour; NZB Low Gluten Bread Mix; Orgran; Healtheries Simple Baking Mix)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

☐ Gluten enteropathy has been diagnosed by biopsy

or

☐ Patient suffers from dermatitis herpetiformis

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1108
June 2012

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: ....

Foods and Supplements For Inborn Errors Of Metabolism (Easiphen Liquid; Loprofin Mix; Loprofin; Minaphlex; MSUD Maxamaid; MSUD Maxamum; Phlexy 10; PKU Anamix Junior LQ; PKU Lophlex LQ; PKU Anamix Infant; XP Maxamaid; XP Maxamum; XMET Maxamum)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.

Prerequisites (tick boxes where appropriate)

- ☐ Dietary management of homocystinuria

or

- ☐ Dietary management of maple syrup urine disease

or

- ☐ Dietary management of phenylketonuria (PKU)

or

- ☐ For use as a supplement to the Ketogenic diet in patients diagnosed with epilepsy

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1109
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Infant Formulae - For Premature Infants (S26LBW Gold RTF)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick box where appropriate)

❑ The patient is infant weighing less than 1.5 kg at birth

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1198
June 2012

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Preterm post-discharge infant formula powder (S-26 Gold Premgro)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

☐ The infant was born before 33 weeks gestation or weighed less than 1.5 kg at birth

and

☐ The infant has faltering growth (downward crossing of percentiles)

or

☐ The infant is not maintaining, or is considered unlikely to maintain, adequate growth on standard infant formula

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1110
June 2012

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: ....

Infant Formulae - For Williams Syndrome (Locasol)

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box where appropriate)

❑ The patient is an infant suffering from Williams Syndrome and associated hypercalcaemia

RENEWAL

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

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.

Prerequisites (tick box, and write the data requested in the space provided where appropriate)

❑ The treatment remains appropriate and the patient is benefiting from treatment

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1111
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Amino acid formula (Elecare; Neocate; Vivonex)

INITIAL APPLICATION - Transition from Old Form (SA0603)
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- ☐ The patient is currently receiving funded amino acid formula under Special Authority form SA0603

and

- ☐ An assessment as to whether the infant can be transitioned to a cows milk protein, soy, or extensively hydrolysed infant formula has been undertaken

and

- ☐ The outcome of the assessment is that the infant continues to require an amino acid infant formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted: ....

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Extensively hydrolysed formula has been reasonably trialled and is inappropriate due to documented severe intolerance or allergy or malabsorption

or

- ☐ History of anaphylaxis to cows milk protein formula or dairy products

or

- ☐ Eosinophilic oesophagitis

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- ☐ An assessment as to whether the infant can be transitioned to a cows milk protein, soy, or extensively hydrolysed infant formula has been undertaken

and

- ☐ The outcome of the assessment is that the infant continues to require an amino acid infant formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1112
June 2012

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: ....

Extensively hydrolysed formula (Pepti Junior Gold)

INITIAL APPLICATION - Transition from Old Form (SA0603)
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- ☐ The infant is currently receiving funded amino acid formula under Special Authority form SA0603

and

- ☐ The infant is to be trialled on, or transitioned to, an extensively hydrolysed formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted: ....

or

- ☐ The patient is currently receiving funded extensively hydrolysed formula under Special Authority form SA0603

and

- ☐ An assessment as to whether the infant can be transitioned to a cows milk protein or soy infant formula has been undertaken

and

- ☐ The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted: ....

Use next page for: Initial application, Renewal and Renewal - Step Down from Amino Acid Formula

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

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Extensively hydrolysed formula (Pepti Junior Gold) - continued

INITIAL APPLICATION
Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes where appropriate)

- ☐ Cows milk formula is inappropriate due to severe intolerance or allergy to its protein content

  and

  - ☐ Soy milk formula has been trialled without resolution of symptoms

    or

  - ☐ Soy milk formula is considered clinically inappropriate or contraindicated

or
- ☐ Severe malabsorption

or
- ☐ Short bowel syndrome

or
- ☐ Intractable diarrhea

or
- ☐ Biliary atresia

or
- ☐ Cholestatic liver diseases causing malsorption

or
- ☐ Chylous ascite

or
- ☐ Chylothorax

or
- ☐ Cystic fibrosis

or
- ☐ Proven fat malabsorption

or
- ☐ Severe intestinal motility disorders causing significant malabsorption

or
- ☐ Intestinal failure

Use next page for: Renewal and Renewal - Step Down from Amino Acid Formula

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1112
June 2012

APPLICANT (stamp or sticker acceptable)
Reg No: ....
Name: ....
Address: ....
....
....
Fax Number: ....

PATIENT NHI: ....
First Names: ....
Surname: ....
DOB: ....
Address: ....
....
....

REFERRER Reg No: ....
First Names: ....
Surname: ....
Address: ....
....
....
Fax Number: ....

Extensively hydrolysed formula (Pepti Junior Gold) - continued

RENEWAL

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- [ ] An assessment as to whether the infant can be transitioned to a cows milk protein or soy infant formula has been undertaken

and

- [ ] The outcome of the assessment is that the infant continues to require an extensively hydrolysed infant formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted:
....

RENEWAL - Step Down from Amino Acid Formula

Current approval Number (if known):..

Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 6 months.

Prerequisites (tick boxes, and write the data requested in the space provided where appropriate)

- [ ] The infant is currently receiving funded amino acid formula

and

- [ ] The infant is to be trialled on, or transitioned to, an extensively hydrolysed formula

and

General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and the date contacted: ....

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

Ministry of Health
Phone 0800 243 666

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1197
June 2012

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: ....

High fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (KetoCal)

INITIAL APPLICATION
Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months.

Prerequisites (tick box where appropriate)

- ❑ The patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet

RENEWAL

Current approval Number (if known):..

Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years.

Prerequisites (tick box where appropriate)

- ❑ The patient is on a ketogenic diet and the patient is benefiting from the diet

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

SA0053 Bee Venom Allergy Treatment; Wasp venom allergy treatment (Circle one) ... 148
SA0090 Desmopressin – Inj 4 µg per ml, 1 ml ... 40
SA0256 Perhexiline Maleate ... 25
SA0473 Imiglucerase ... 4
SA0500 Combined oral contraceptives; Progestogen-only contraceptives (Circle one)... 31
SA0611 Dornase Alfa ... 4
SA0643 Imatinib Mesylate ... 4
SA0669 Tacrolimus ... 145
SA0755 Growth Hormone Biosynthetic Human ... 4
SA0782 Levonorgestrel – releasing intrauterine system 20µg/24 hr ... 38
SA0829 Adefovir dipivoxil ... 49
SA0832 Lamivudine ... 47
SA0845 Enfuvirtide ... 57
SA0863 Buspirone Hydrochloride ... 101
SA0866 Sirolimus (Rapamune) ... 146
SA0878 Irinotecan ... 115
SA0879 Anagrelide Hydrochloride ... 121
SA0891 Macrogol 3350 (Movicol) ... 10
SA0895 Pilocarpine – Eye drops 2% single dose ... 152
SA0900 Oxaliplatin ... 112
SA0906 Lignocaine with Prilocaine ... 88
SA0909 Naltrexone ... 109
SA0920 Aripiprazole ... 97
SA0922 Erythropoietin ... 14
SA0923 Imiquimod ... 29
SA0926 Risperidone microspheres ... 98
SA0927 Risperidone orally disintegrating tablets ... 100
SA0928 Finasteride ... 32
SA0933 Candesartan ... 23
SA0934 Midodrine ... 24
SA0939 Hyoscine (Scopolamine) ... 95
SA0941 Bicalutamide ... 135
SA0949 Alendronate for Paget's Disease (Alendronate Tab 40 mg) ... 81
SA0951 Atomoxetine ... 107
SA0954 Acitretin ... 28
SA0955 Isotretinoin ... 27
SA0957 Valaciclovir ... 51
SA0959 Pioglitazone ... 8
SA0967 Endothelin Receptor Antagonists ... 4
SA0969 Iiloprost ... 4
SA0973 Neurontin ... 4
SA0976 Dasatinib ... 4
SA0977 Entecavir ... 50
SA0987 Aprepitant ... 96
SA0994 Mirtazapine ... 91
SA0998 Solifenacin succinate ... 35
SA1002 Vitabdeck ... 11
SA1013 Vinorelbine ... 119
SA1016 Octreotide (somatostatin analogue) ... 132
SA1018 Hormone Replacement Therapy - Systemic ... 37
SA1025 Antiretrovirals ... 54
SA1031 Cabergoline ... 41
SA1032 Tamsulosin ... 33
SA1034 Meloxicam ... 61
SA1036 Multivitamins (Paediatric Seravit) ... 12
SA1038 Anti-inflammatory Non Steroidal Drugs (NSAIDs) ... 4
SA1039 Alendronate Tab 70 mg - with or without Cholecalciferol ... 79
SA1041 Mycophenolate mofetil ... 136
SA1042 Deferiprone ... 21
SA1044 Erlotinib ... 126
SA1045 Ezetimibe ... 18
SA1046 Ezetimibe with Simvastatin (Vytorin) ... 20
SA1047 Tenofovir ... 52
SA1048 Mianserin Hydrochloride ... 89
SA1049 Capecitabine ... 113
SA1061 Venlafaxine ... 90
SA1062 Multiple Sclerosis Treatments ... 4
SA1063 Temozolomide ... 123
SA1065 Moxifloxacin ... 45
SA1066 Rivaroxaban ... 17
SA1071 Gabapentin ... 93
SA1072 Vigabatrin ... 92
SA1083 Potassium Citrate ... 34
SA1086 Sildenafil ... 4
SA1087 Gemcitabine hydrochloride ... 116
SA1090 Carbohydrate (Moducal; Polycal) ... 154
SA1091 Carbohydrate and Fat (Duocal Super Soluble Powder) ... 156
SA1092 Fat (Calogen; Liquigen; MCT oil (Nutricia)) ... 158
SA1093 Protein (Protifar; Promod; Resource Beneprotein) ... 160
SA1094 CORD Products (Pulmocare) ... 161
SA1095 Diabetic products (Diason RTH; Glucerna Select RTH; Diasip; Glucerna Select; Resource Diabetic) ... 162
SA1096 Fat Modified Products (Monogen) ... 163
SA1097 High Protein Products (Fortimel Regular) ... 164
SA1098 Paediatric Product For Children Awaiting Liver Transplant (Generaid Plus) ... 165
SA1099 Paediatric Product For Children With Chronic Renal Failure (Kindergen) ... 166
SA1100 Paediatric Products (Nutrini; Pediasure; Fortini) ... 167
SA1101 Renal Products (Nepro; NovaSource Renal; Renilon 7.5) ... 168
SA1102 Specialised And Elemental Products (Alitraq; Elemental 028 Extra; Peptisorb; Vital HN; Vivonex TEN) ... 169
SA1103 Products for Undialysed End Stage Renal Failure (Suplena) ... 170
SA1104 Standard Supplements (Ensure; Fortisip; Isosource; Jevity; Nutrison; Osmolite; Sustagen) ... 172
SA1106 Food Thickeners (Karicare Food Thickener) ... 179
SA1107 Gluten Free Foods (Bakels Gluten Free Health Bread Mix; Horleys Bread Mix; Horleys Flour; NZB Low Gluten Bread Mix; Orgran; Healtheries Simple Baking Mix) ... 180
SA1108 Foods and Supplements For Inborn Errors Of Metabolism (Easiphen Liquid; Loprofin Mix; Loprofin; Minaphlex; MSUD Maxamaid; MSUD Maxamum; Phlexy 10; PKU Anamix Junior LQ; PKU Lophlex LQ; PKU Anamix Infant; XP Maxamaid; XP Maxamum; XMET Maxamum) ... 181
SA1109 Infant Formulae - For Premature Infants (S26LBW Gold RTF) ... 182
SA1110 Infant Formulae - For Williams Syndrome (Locasol) ... 184
SA1111 Amino acid formula (Elecare; Neocate; Vivonex) ... 185
SA1112 Extensively hydrolysed formula (Pepti Junior Gold) ... 186
SA1124 Thalidomide ... 122
SA1125 Lacosamide ... 94
SA1126 Modavigil ... 108
SA1127 bortezomib ... 124
SA1130 Azithromycin ... 43
SA1131 Clarithromycin ... 44
SA1134 Pegylated Interferon alpha-2A ... 58
SA1138 Raloxifene ... 85
SA1139 Teriparatide ... 86
SA1146 Olanzapine depot injection ... 99
SA1148 fluconazole oral liquid ... 46
SA1149 Dexamphetamine Sulphate ... 102
SA1150 Methylphenidate Hydrochloride (Rubifen; Rubifen SR; Ritalin; Ritalin SR) ... 104
SA1151 Methylphenidate Hydrochloride Extended Release (Concerta; Ritalin LA) ... 106
SA1152 Rituximab ... 137
SA1155 Budesonide - Cap 3 mg Controlled Release ... 6
SA1156 Adalimumab ... 70
SA1157 Etanercept ... 62
SA1161 Varenicline tartrate ... 110
SA1174 Enoxaparin sodium ... 16
SA1179 Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists ... 149
SA1187 Zoledronic acid ... 82
SA1188 Ursodeoxycholic Acid ... 9
SA1190 Pazopanib ... 129
SA1191 Lapatinib ... 131
SA1192 Trastuzumab ... 142
SA1193 Tiotropium Bromide ... 150
SA1195 Adult Products High Calorie (Two Cal HN; Nutrison Concentrated) ... 177

SA1196 Paediatric enteral feed with fibre 0.75 kcal/ml (Nutrini Low Energy Multi Fibre) 171
SA1197 High fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (KetoCal) 189
SA1198 Preterm post-discharge infant formula powder (S-26 Gold Premgro) 183
SA1199 Propylthiouracil 39
SA1200 Sunitinib 127
SA1201 Prasugrel 15

Index

Acitretin (SA0954) ... 28
Adalimumab (SA1156) ... 70
Adefovir dipivoxil (SA0829) ... 49
Adult Products High Calorie (SA1195) ... 177
Alendronate Tab 70 mg - with or without Cholecalciferol (SA1039) ... 79
Alendronate for Paget's Disease (SA0949) ... 81
Amino acid formula (SA1111) ... 185
Anagrelide Hydrochloride (SA0879) ... 121
Anti-inflammatory Non Steroidal Drugs (NSAIDs) (SA1038) ... 4
Antiretrovirals (SA1025) ... 54
Aprepitant (SA0987) ... 96
Aripiprazole (SA0920) ... 97
Atomoxetine (SA0951) ... 107
Azithromycin (SA1130) ... 43
Bee Venom Allergy Treatment (SA0053) ... 148
Bicalutamide (SA0941) ... 135
Budesonide - Cap 3 mg Controlled Release (SA1155) ... 6
Buspirone Hydrochloride (SA0863) ... 101
CORD Products (SA1094) ... 161
Cabergoline (SA1031) ... 41
Candesartan (SA0933) ... 23
Capecitabine (SA1049) ... 113
Carbohydrate and Fat (SA1091) ... 156
Carbohydrate (SA1090) ... 154
Clarithromycin (SA1131) ... 44
Combined oral contraceptives (SA0500) ... 31
Dasatinib (SA0976) ... 4
Deferiprone (SA1042) ... 21
Desmopressin – Inj 4 µg per ml, 1 ml (SA0090) ... 40
Dexamphetamine Sulphate (SA1149) ... 102
Diabetic products (SA1095) ... 162
Dornase Alfa (SA0611) ... 4
Endothelin Receptor Antagonists (SA0967) ... 4
Enfuvirtide (SA0845) ... 57
Enoxaparin sodium (SA1174) ... 16
Entecavir (SA0977) ... 50
Erlotinib (SA1044) ... 126
Erythropoietin (SA0922) ... 14
Etanercept (SA1157) ... 62
Extensively hydrolysed formula (SA1112) ... 186
Ezetimibe (SA1045) ... 18
Ezetimibe with Simvastatin (SA1046) ... 20
Fat Modified Products (SA1096) ... 163
Fat (SA1092) ... 158
Finasteride (SA0928) ... 32
Food Thickeners (SA1106) ... 179
Foods and Supplements For Inborn Errors Of Metabolism (SA1108) ... 181
Gabapentin (SA1071) ... 93
Gemcitabine hydrochloride (SA1087) ... 116
Gluten Free Foods (SA1107) ... 180
Growth Hormone Biosynthetic Human (SA0755) ... 4
High Protein Products (SA1097) ... 164
High fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (SA1197) ... 189
Hormone Replacement Therapy - Systemic (SA1018) ... 37
Hyoscine (Scopolamine) (SA0939) ... 95
Iiloprost (SA0969) ... 4
Imatinib Mesylate (SA0643) ... 4
Imiglucerase (SA0473) ... 4
Imiquimod (SA0923) ... 29
Infant Formulae - For Premature Infants (SA1109) ... 182
Infant Formulae - For Williams Syndrome (SA1110) ... 184
Inhaled Corticosteroids with Long-Acting Beta-Adrenoceptor Agonists (SA1179) ... 149
Irinotecan (SA0878) ... 115
Isotretinoin (SA0955) ... 27
Lacosamide (SA1125) ... 94
Lamivudine (SA0832) ... 47
Lapatinib (SA1191) ... 131
Levonorgestrel – releasing intrauterine system 20µg/24 hr (SA0782) ... 38
Lignocaine with Prilocaine (SA0906) ... 88
Macrogol 3350 (SA0891) ... 10
Meloxicam (SA1034) ... 61
Methylphenidate Hydrochloride Extended Release (SA1151) ... 106
Methylphenidate Hydrochloride (SA1150) ... 104
Mianserin Hydrochloride (SA1048) ... 89
Midodrine (SA0934) ... 24
Mirtazapine (SA0994) ... 91
Modavigil (SA1126) ... 108
Moxifloxacin (SA1065) ... 45
Multiple Sclerosis Treatments (SA1062) ... 4
Multivitamins (SA1036) ... 12
Mycophenolate mofetil (SA1041) ... 136
Naltrexone (SA0909) ... 109
Neurontin (SA0973) ... 4
Octreotide (somatostatin analogue) (SA1016) ... 132
Olanzapine depot injection (SA1146) ... 99
Oxaliplatin (SA0900) ... 112
Paediatric Product For Children Awaiting Liver Transplant (SA1098) ... 165
Paediatric Product For Children With Chronic Renal Failure (SA1099) ... 166
Paediatric Products (SA1100) ... 167
Paediatric enteral feed with fibre 0.75 kcal/ml (SA1196) ... 171
Pazopanib (SA1190) ... 129
Pegylated Interferon alpha-2A (SA1134) ... 58
Perhexiline Maleate (SA0256) ... 25
Pilocarpine – Eye drops 2% single dose (SA0895) ... 152
Pioglitazone (SA0959) ... 8
Potassium Citrate (SA1083) ... 34
Prasugrel (SA1201) ... 15
Preterm post-discharge infant formula powder (SA1198) ... 183
Products for Undialysed End Stage Renal Failure (SA1103) ... 170
Progestogen-only contraceptives (SA0500) ... 31
Propylthiouracil (SA1199) ... 39
Protein (SA1093) ... 160
Raloxifene (SA1138) ... 85
Renal Products (SA1101) ... 168
Risperidone microspheres (SA0926) ... 98
Risperidone orally disintegrating tablets (SA0927) ... 100
Rituximab (SA1152) ... 137
Rivaroxaban (SA1066) ... 17
Sildenafil (SA1086) ... 4
Sirolimus (Rapamune) (SA0866) ... 146
Solifenacin succinate (SA0998) ... 35
Specialised And Elemental Products (SA1102) ... 169
Standard Supplements (SA1104) ... 172
Sunitinib (SA1200) ... 127
Tacrolimus (SA0669) ... 145
Tamsulosin (SA1032) ... 33
Temozolomide (SA1063) ... 123
Tenofovir (SA1047) ... 52
Teriparatide (SA1139) ... 86
Thalidomide (SA1124) ... 122
Tiotropium Bromide (SA1193) ... 150
Trastuzumab (SA1192) ... 142
Ursodeoxycholic Acid (SA1188) ... 9
Valaciclovir (SA0957) ... 51
Varenicline tartrate (SA1161) ... 110
Venlafaxine (SA1061) ... 90
Vigabatrin (SA1072) ... 92
Vinorelbine (SA1013) ... 119
Vitabdeck (SA1002) ... 11
Wasp venom allergy treatment (SA0053) ... 148
Zoledronic acid (SA1187) ... 82
bortezomib (SA1127) ... 124
fluconazole oral liquid (SA1148) ... 46