Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1955
October 2021

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: .....

Ticagrelor

Initial application — acute coronary syndrome
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome

and

- ☐ Fibrinolytic therapy has not been given in the last 24 hours and is not planned

Initial application — thrombosis prevention neurological stenting
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has had a neurological stenting procedure* in the last 60 days

or

- ☐ Patient is about to have a neurological stenting procedure performed*

and

- ☐ Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor

or

- ☐ Clopidogrel resistance has been demonstrated by the occurrence of a new cerebral ischemic event

or

- ☐ Clopidogrel resistance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the stent

Initial application — Percutaneous coronary intervention with stent deployment
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone percutaneous coronary intervention

and

- ☐ Patient has had a stent deployed in the previous 4 weeks

and

- ☐ Patient is clopidogrel-allergic**

Initial application — Stent thrombosis
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

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 – email: customerservice@health.govt.nz

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

Ticagrelor *- continued*

Renewal — subsequent acute coronary syndrome

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

Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome

and

- ☐ Fibrinolytic therapy has not been given in the last 24 hours and is not planned

Renewal — thrombosis prevention neurological stenting

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

Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is continuing to benefit from treatment

and

- ☐ Treatment continues to be clinically appropriate

Renewal — Percutaneous coronary intervention with stent deployment

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone percutaneous coronary intervention

and

- ☐ Patient has had a stent deployed in the previous 4 weeks

and

- ☐ Patient is clopidogrel-allergic**

Note: indications marked with * are unapproved indications.
Note: 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: .....
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