Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1992
October 2021

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: ....

Sildenafil

Initial application — Raynaud's Phenomenon*
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has Raynaud's Phenomenon*

and

- ☐ Patient has severe digital ischaemia (defined as severe pain requiring hospital admission or with a high likelihood of digital ulceration; digital ulcers; or gangrene)

and

- ☐ Patient is following lifestyle management (avoidance of cold exposure, sufficient protection, smoking cessation support, avoidance of sympathomimetic drugs)

and

- ☐ Patient is being treated with calcium channel blockers and nitrates (or these are contraindicated/not tolerated)

Initial application — Pulmonary arterial hypertension*
Applications only from a respiratory specialist, cardiologist or medical practitioner on the recommendation of a respiratory specialist or cardiologist. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has pulmonary arterial hypertension (PAH)*

and

- ☐ PAH is in Group 1 of the WHO (Venice) clinical classifications

  or

- ☐ PAH is in Group 4 of the WHO (Venice) clinical classifications

  or

- ☐ PAH is in Group 5 of the WHO (Venice) clinical classifications

and

- ☐ PAH is in NYHA/WHO functional class II

  or

- ☐ PAH is in NYHA/WHO functional class III

  or

- ☐ PAH is in NYHA/WHO functional class IV

and

- ☐ Patient has a pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg

  and

  - ☐ Patient has a mean pulmonary artery pressure (PAPm) > 25 mmHg

    or

  - ☐ Patient is peri Fontan repair

  and

- ☐ Patient has a pulmonary vascular resistance (PVR) of at least 3 Wood Units or at least 240 International Units (dyn s cm-5)

or

- ☐ Testing for PCWP, PAPm, or PVR cannot be performed due to the patient's young age

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 – email: customerservice@health.govt.nz

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

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Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

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Address: ....

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REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Sildenafil *- continued*

Initial application — erectile dysfunction due to spinal cord injury
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient has a documented history of traumatic or non-traumatic spinal cord injury

and

- [ ] Patient has erectile dysfunction secondary to spinal cord injury requiring pharmacological treatment

Renewal — erectile dysfunction due to spinal cord injury

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 – email: customerservice@health.govt.nz