# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY



**Form SA2008**
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: ..... |

## Everolimus

**Initial application**
Applications only from a neurologist or oncologist. Approvals valid for 3 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has tuberous sclerosis

**and**

- ☐ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

**Renewal**

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

Applications only from a neurologist or oncologist. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months

**and**

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

**and**

- ☐ Everolimus to be discontinued at progression of SEGAs

Note: MRI should be performed at minimum once every 12 months, more frequent scanning should be performed with new onset of symptoms such as headaches, visual complaints, nausea or vomiting, or increase in seizure activity.

**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**