Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1895**
November 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: ..... |

## Fulvestrant

**Initial application**
Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer

**and**

- ☐ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease

**and**

- ☐ Treatment to be given at a dose of 500 mg monthly following loading doses

**and**

- ☐ Treatment to be discontinued at disease progression

**Renewal**

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Treatment remains appropriate and patient is benefitting from treatment

**and**

- ☐ Treatment to be given at a dose of 500 mg monthly

**and**

- ☐ There is no evidence of 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 – email: customerservice@health.govt.nz**