Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2115**
May 2024

| **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: ..... |

## Erlotinib

**Initial application**
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has locally advanced or metastatic, unresectable, non-squamous Non Small Cell Lung Cancer (NSCLC)

**and**

- ☐ There is documentation confirming that the disease expresses activating mutations of EGFR tyrosine kinase

**and**

- ☐ Patient is treatment naive

**or**

- ☐ The patient has discontinued gefitinib due to intolerance

**and**

- ☐ The cancer did not progress while on gefitinib

**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 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

**Renewal — pandemic circumstances**

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

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

- ☐ The patient is clinically benefiting from treatment and continued treatment remains appropriate

**and**

- ☐ Erlotinib to be discontinued at progression

**and**

- ☐ The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector

**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**