Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2008
June 2024

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: ....

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

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