Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2331
July 2025

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: .....

Mepolizumab

Initial application — Severe eosinophilic asthma
Applications only from a respiratory physician or clinical immunologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient must be aged 12 years or older
- **and** ☐ Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist
- **and** ☐ Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been excluded
- **and** ☐ Patient has a blood eosinophil count of greater than 0.5 × 10^9 cells/L in the last 12 months
- **and** ☐ Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliever therapy regimen, unless contraindicated or not tolerated
- **and**
  - ☐ Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation is defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids
  - **or** ☐ Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months
- **and** ☐ Treatment is not to be used in combination with subsidised benralizumab
- **and** ☐ Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to assess response to treatment
- **and**
  - ☐ Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma
  - **or**
    - ☐ Patient was refractory or intolerant to previous anti-IL5 biological therapy
    - **and** ☐ Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 12 months of commencing treatment

Renewal — Severe eosinophilic asthma

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

Applications only from a respiratory physician or clinical immunologist. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ An increase in the Asthma Control Test (ACT) score of at least 5 from baseline
- **and**
  - ☐ Exacerbations have been reduced from baseline by 50% as a result of treatment with mepolizumab
  - **or** ☐ Reduction in continuous oral corticosteroid use by 50% or by 10 mg/day while maintaining or improving asthma control

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

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.....	.....	.....
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Mepolizumab *- continued*

Initial application — eosinophilic granulomatosis with polyangiitis
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has eosinophilic granulomatosis with polyangiitis

and

- ☐ The patient has trialled and not received adequate benefit from at least one of the following for at least three months (unless contraindicated to all): azathioprine, cyclophosphamide, leflunomide, methotrexate, mycophenolate, or rituximab

and

- ☐ The patient has trialled prednisone for a minimum of three months and is unable to maintain disease control at doses below 7.5 mg per day

or

- ☐ Corticosteroids are contraindicated

Renewal — eosinophilic granulomatosis with polyangiitis

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

- ☐ Patient has no evidence of clinical disease progression

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....
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