Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2484
June 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: .....

Dabrafenib

Initial application — stage III or IV resected melanoma - adjuvant
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

☐ The individual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment

or

☐ The individual has resected stage IIIB, IIIC, IIID or IV melanoma (excluding uveal) (see note a)

or

☐ The individual has received neoadjuvant treatment with a PD-1/PD-L1 inhibitor

and

☐ Adjuvant treatment with dabrafenib is required

and

☐ The individual has not received prior funded systemic treatment in the adjuvant setting for stage IIIB, IIIC, IIID or IV melanoma

and

☐ Treatment must be adjuvant to complete surgical resection

and

☐ Treatment must be initiated within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see note b)

and

☐ The individual has a confirmed BRAF mutation

and

☐ Dabrafenib must be administered in combination with trametinib

and

☐ The individual has ECOG performance score 0-2

Note:

a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition

b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)

Renewal — stage III or IV resected melanoma - adjuvant

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

Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

☐ No evidence of disease recurrence

and

☐ Dabrafenib must be administered in combination with trametinib

and

☐ Treatment to be discontinued at signs of disease recurrence or at completion of 12 months' total treatment course, including any systemic neoadjuvant treatment

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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.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Dabrafenib *- continued*

Initial application — unresectable or metastatic melanoma
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ The individual is currently on treatment with dabrafenib and trametinib and met all remaining criteria prior to commencing treatment

or

- ☐ The individual has metastatic or unresectable melanoma (excluding uveal) stage III or IV

and

- ☐ Baseline measurement of overall tumour burden is documented clinically and radiologically

and

- ☐ The individual has ECOG performance score 0-2

and

- ☐ The individual has confirmed BRAF mutation

and

- ☐ Dabrafenib must be administered in combination with trametinib

and

- ☐ The individual has been diagnosed in the metastatic or unresectable stage III or IV setting

or

- ☐ The individual did not receive treatment in the adjuvant setting with a BRAF/MEK inhibitor

or

- ☐ The individual received treatment in the adjuvant setting with a BRAF/MEK inhibitor

and

- ☐ The individual did not experience disease recurrence while on treatment with that BRAF/MEK inhibitor

and

- ☐ The individual did not experience disease recurrence within six months of completing adjuvant treatment with a BRAF/MEK inhibitor

Renewal — unresectable or metastatic melanoma

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

Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ The individual's disease has had a complete response to treatment

or

- ☐ The individual's disease has had a partial response to treatment

or

- ☐ The individual has stable disease with treatment

and

- ☐ Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

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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