Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2488**
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: ..... |

## Secukinumab

**Initial application — severe chronic plaque psoriasis – second-line biologic**
Applications only from a dermatologist or any relevant practitioner on the recommendation of a dermatologist. Approvals valid for 4 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for adalimumab or etanercept, or has trialled infliximab in a Health NZ Hospital, for severe chronic plaque psoriasis

**and**

- ☐ The patient has experienced intolerable side effects from adalimumab, etanercept or infliximab

**or**

- ☐ The patient has received insufficient benefit from adalimumab, etanercept or infliximab

**and**

- ☐ A Psoriasis Area and Severity Index (PASI) assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

**and**

- ☐ The most recent PASI or DQLI assessment is no more than 1 month old at the time of application

**Initial application — severe chronic plaque psoriasis – first-line biologic**
Applications only from a dermatologist or any relevant practitioner on the recommendation of a dermatologist. Approvals valid for 4 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis

**or**

- ☐ Patient has severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques have been present for at least 6 months from the time of initial diagnosis

**or**

- ☐ Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10

**and**

- ☐ Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin

**and**

- ☐ A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course, preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course

**and**

- ☐ The most recent PASI or DQLI assessment is no more than 1 month old at the time of application

Note: A treatment course is defined as a minimum of 12 weeks of treatment. "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand. foot, genital or flexural areas, at least 2 of the 3 PASI symptom sub scores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior 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**

| **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: ..... |

## Secukinumab *- continued*

**Renewal — severe chronic plaque psoriasis – first and second-line biologic**

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

Applications from any relevant practitioner. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Patient's PASI score has reduced by 75% or more (PASI 75) as compared to baseline PASI prior to commencing secukinumab

  **or**

- ☐ Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab

**or**

- ☐ Patient had severe chronic localised genital or flexural plaque psoriasis at the start of treatment

  **and**

  - ☐ The patient has experienced a reduction of 75% or more in the skin area affected, or sustained at this level, as compared to the pre-treatment baseline value

    **or**

  - ☐ Patient has a Dermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI prior to commencing secukinumab

**and**

- ☐ Secukinumab to be administered at a maximum dose of 300 mg monthly

**Initial application — ankylosing spondylitis – second-line biologic**

Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ The patient has had an initial Special Authority approval for adalimumab and/or etanercept for ankylosing spondylitis

  **and**

  - ☐ The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept

    **or**

  - ☐ Following 12 weeks of adalimumab and/or etanercept treatment, the patient did not meet the renewal criteria for adalimumab and/or etanercept for ankylosing spondylitis

**Renewal — ankylosing spondylitis – second-line biologic**

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

Applications only from a rheumatologist or medical practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.

**Prerequisites**(tick boxes where appropriate)

- ☐ Following 12 weeks initial treatment of secukinumab treatment, BASDAI has improved by 4 or more points from pre-secukinumab baseline on a 10 point scale, or by 50%, whichever is less

  **and**

- ☐ Physician considers that the patient has benefitted from treatment and that continued treatment is appropriate

  **and**

- ☐ Secukinumab to be administered at doses no greater than 300 mg monthly

**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**

| **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: ..... |

## Secukinumab *- continued*

**Initial application — psoriatic arthritis**
Applications only from a rheumatologist. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has had an initial Special Authority approval for adalimumab, etanercept or infliximab for psoriatic arthritis

**and**

  - ☐ Patient has experienced intolerable side effects from adalimumab, etanercept or infliximab

  **or**

  - ☐ Patient has received insufficient benefit from adalimumab, etanercept or infliximab to meet the renewal criteria for adalimumab, etanercept or infliximab for psoriatic arthritis

**or**

- ☐ Patient has had severe active psoriatic arthritis for six months duration or longer

**and**

- ☐ Patient has tried and not responded to at least three months of oral or parenteral methotrexate at a dose of at least 20 mg weekly or a maximum tolerated dose

**and**

- ☐ Patient has tried and not responded to at least three months of sulfasalazine at a dose of at least 2 g per day or leflunomide at a dose of up to 20 mg daily (or maximum tolerated doses)

**and**

  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least 15 swollen, tender joints

  **or**

  - ☐ Patient has persistent symptoms of poorly controlled and active disease in at least four joints from the following: wrist, elbow, knee, ankle, and either shoulder or hip

**and**

  - ☐ Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of this application

  **or**

  - ☐ Patient has an elevated erythrocyte sedimentation rate (ESR) greater than 25 mm per hour

  **or**

  - ☐ ESR and CRP not measured as patient is currently receiving prednisone therapy at a dose of greater than 5 mg per day and has done so for more than three months

**Renewal — psoriatic arthritis**

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

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

- ☐ Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician

**or**

- ☐ The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior secukinumab treatment in the opinion of the treating physician

**and**

- ☐ Secukinumab to be administered at doses no greater than 300 mg monthly

**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**