Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2514**
August 2025

| **APPLICANT** (stamp or sticker acceptable) | **PATIENT** NHI: ..... | **REFERRER** Reg No: ..... |
|---|---|---|
| Reg No: ..... | First Names: ..... | First Names: ..... |
| Name: ..... | Surname: ..... | Surname: ..... |
| Address: ..... | DOB: ..... | Address: ..... |
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| Fax Number: ..... | ..... | Fax Number: ..... |

## Valganciclovir

**Initial application — transplant cytomegalovirus prophylaxis**
Applications only from a relevant specialist. Approvals valid for 3 months.
**Prerequisites**(tick box where appropriate)

☐ The patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis

**Renewal — transplant cytomegalovirus prophylaxis**

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

Applications only from a relevant specialist. Approvals valid for 3 months.
**Prerequisites**(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis
**and**
☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin

**or**

☐ Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis
**and**
☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone

**Initial application — cytomegalovirus prophylaxis following anti-thymocyte globulin**
Applications only from a relevant specialist. Approvals valid for 3 months.
**Prerequisites**(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months)
**and**
☐ Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

**Renewal — cytomegalovirus prophylaxis following anti-thymocyte globulin**

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

Applications only from a relevant specialist. Approvals valid for 3 months.
**Prerequisites**(tick box where appropriate)

☐ The patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

**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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## Valganciclovir *- continued*

**Initial application — Lung transplant cytomegalovirus prophylaxis**
Applications only from a relevant specialist. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has undergone a lung transplant

**and**

- ☐ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

**or**

- ☐ The recipient is cytomegalovirus positive

**and**

- ☐ Patient has a high risk of CMV disease

**Renewal — Lung transplant cytomegalovirus prophylaxis**

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

Applications only from a relevant specialist. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has undergone a lung re-transplant

**and**

- ☐ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

**or**

- ☐ The recipient is cytomegalovirus positive

**and**

- ☐ Patient has a high risk of CMV disease

**Initial application — Cytomegalovirus in immunocompromised patients**
Applications only from a relevant specialist. Approvals valid for 3 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient is immunocompromised

**and**

- ☐ Patient has cytomegalovirus syndrome or tissue invasive disease

**or**

- ☐ Patient has rapidly rising plasma CMV DNA in absence of disease

**or**

- ☐ Patient has cytomegalovirus retinitis

**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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## Valganciclovir *- continued*

**Renewal — Cytomegalovirus in immunocompromised patients**

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

Applications only from a relevant specialist. Approvals valid for 3 months.

**Prerequisites**(tick boxes where appropriate)

☐ Patient is immunocompromised

**and**

☐ Patient has cytomegalovirus syndrome or tissue invasive disease

**or**

☐ Patient has rapidly rising plasma CMV DNA in absence of disease

**or**

☐ Patient has cytomegalovirus retinitis

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

**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**