Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2618
March 2026

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: .....

Pegaspargase

Initial application — Acute lymphoblastic leukaemia
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 15 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has newly diagnosed acute lymphoblastic leukaemia

and

- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

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

- ☐ The patient has lymphoma requiring L-asparaginase containing protocols (e.g. SMILE)

Renewal — Acute lymphoblastic leukaemia

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

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

- ☐ The patient has relapsed acute lymphoblastic leukaemia

and

- ☐ Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol

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

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

Post application to Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz