Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2635
May 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Letermovir

Initial application — CMV prophylaxis - post HSCT
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient has undergone an allogeneic haematopoietic stem cell transplant

and
- [ ] The patient has confirmed presence of cytomegalovirus-specific antibodies

and
- [ ] Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant

and
- [ ] Maximum treatment duration of 100 days post-transplant

Renewal — CMV prophylaxis – second or subsequent HSCT

Current approval Number (if known):..

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

- [ ] Patient has undergone an allogeneic haematopoietic stem cell transplant

and
- [ ] The patient has confirmed presence of cytomegalovirus-specific antibodies

and
- [ ] Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant

and
- [ ] Maximum treatment duration of 100 days post-transplant

Initial application — CMV prophylaxis - severe immunosuppression*
Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient has severe immunosuppression requiring prophylaxis of CMV

and
  - [ ] Patient is contraindicated to all other funded CMV active oral antiviral agents

  or
  - [ ] Patient's CMV is resistant to all other funded CMV active oral antiviral agents

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

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First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Letermovir *- continued*

Renewal — CMV prophylaxis - severe immunosuppression*

Current approval Number (if known):..

Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient has severe immunosuppression requiring prophylaxis of CMV

and

- ☐ Patient is contraindicated to all other funded CMV active oral antiviral agents

or

- ☐ Patient's CMV is resistant to all other funded CMV active oral antiviral agents

Note: Indications marked with * are unapproved indications.

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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