Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2008
July 2024

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: .....

Everolimus

Initial application
Applications only from a neurologist or oncologist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has tuberous sclerosis

and

- ☐ Patient has progressively enlarging sub-ependymal giant cell astrocytomas (SEGAs) that require treatment

Renewal

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

Applications only from a neurologist or oncologist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Documented evidence of SEGA reduction or stabilisation by MRI within the last 3 months

and

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

and

- ☐ Everolimus to be discontinued at progression of SEGAs

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