Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2183
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: .....

Vedolizumab

Initial application — Crohn's disease - adults
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has active Crohn's disease

and

☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

or

☐ Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10

or

☐ Patient has extensive small intestine disease affecting more than 50 cm of the small intestine

or

☐ Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection

or

☐ Patient has an ileostomy or colostomy, and has intestinal inflammation

and

☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

or

☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

or

☐ Immunomodulators and corticosteroids are contraindicated

Renewal — Crohn's disease - adults

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

Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

☐ CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy

or

☐ CDAI score is 150 or less, or HBI is 4 or less

or

☐ The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed

and

☐ Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

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: .....

Vedolizumab *- continued*

Initial application — Crohn's disease - children*
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ Paediatric patient has active Crohn's disease

and

☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

or

☐ Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30

or

☐ Patient has extensive small intestine disease

and

☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

or

☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

or

☐ Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with * is an unapproved indication.

Renewal — Crohn's disease - children*

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

Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

☐ PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy

or

☐ PCDAI score is 15 or less

or

☐ The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

and

☐ Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

Note: Indication marked with * is an unapproved indication.

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: .....

Vedolizumab *- continued*

Initial application — ulcerative colitis
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has active ulcerative colitis

and

- ☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

or

- ☐ Patient has a SCCAI score is greater than or equal to 4

or

- ☐ Patient's PUCAI score is greater than or equal to 20*

and

- ☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

or

- ☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

or

- ☐ Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with * is an unapproved indication.

Renewal — ulcerative colitis

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

Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy

or

- ☐ The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *

and

- ☐ Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

Note: Indication marked with * is an unapproved indication.

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