Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2166**
January 2025

| **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: ..... |

## Tolvaptan

**Initial application — autosomal dominant polycystic kidney disease**
Applications only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

- ☐ Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease

**and**

- ☐ Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 $m^2$ at treatment initiation

**and**

- ☐ Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 $m^2$ within one-year

**or**

- ☐ Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 $m^2$ per year over a five-year period

**Renewal — autosomal dominant polycystic kidney disease**

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

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

- ☐ Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 $m^2$

**and**

- ☐ Patient has not undergone a kidney transplant

**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**