Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2266
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: .....

Hypoplastic and Haemolytic

Initial application — chronic renal failure
Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ Patient in chronic renal failure
- **and** ☐ Haemoglobin is less than or equal to 100g/L
- **and**
  - ☐ Patient does not have diabetes mellitus
  - **and** ☐ Glomerular filtration rate is less than or equal to 30ml/min
  - **or**
  - ☐ Patient has diabetes mellitus
  - **and** ☐ Glomerular filtration rate is less than or equal to 45ml/min
  - **or** ☐ Patient is on haemodialysis or peritoneal dialysis

Initial application — myelodysplasia
Applications from any specialist. Approvals valid for 2 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has a confirmed diagnosis of myelodysplasia (MDS)*
- **and** ☐ Has had symptomatic anaemia with haemoglobin < 100g/L and is red cell transfusion-dependent
- **and** ☐ Patient has very low, low or intermediate risk MDS based on the WHO classification based prognostic scoring system for myelodysplastic syndrome (WPSS)
- **and** ☐ Other causes of anaemia such as B12 and folate deficiency have been excluded
- **and** ☐ Patient has a serum epoetin level of < 500 IU/L
- **and** ☐ The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

Note: Indication marked with * is an unapproved indication

Renewal — chronic renal failure

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

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

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

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: .....

Hypoplastic and Haemolytic *- continued*

Renewal — myelodysplasia

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

Applications from any specialist. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ The patient's transfusion requirement continues to be reduced with erythropoietin treatment

and

- ☐ Transformation to acute myeloid leukaemia has not occurred

and

- ☐ The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week

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