Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2405
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: .....

Nivolumab

Initial application
Applications only from a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has metastatic or unresectable melanoma (excluding uveal) stage III or IV

and

- ☐ Baseline measurement of overall tumour burden is documented clinically and radiologically

and

- ☐ The patient has ECOG performance score of 0-2

and

- ☐ Patient has not received funded pembrolizumab

or

- ☐ Patient has received an initial Special Authority approval for pembrolizumab and has discontinued pembrolizumab within 12 weeks of starting treatment due to intolerance

and

- ☐ The cancer did not progress while the patient was on pembrolizumab

and

- ☐ Documentation confirming that the patient has been informed and acknowledges that funded treatment with nivolumab will not be continued if their disease progresses

Renewal — less than 24 months on treatment

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient's disease has had a complete response to treatment

or

- ☐ Patient's disease has had a partial response to treatment

or

- ☐ Patient has stable disease

and

- ☐ Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

and

- ☐ The treatment remains clinically appropriate and the patient is benefitting from the treatment

or

- ☐ Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression

and

- ☐ Patient has signs of disease progression

and

- ☐ Disease has not progressed during previous treatment with nivolumab

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

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.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Nivolumab *- continued*

Renewal — more than 24 months on treatment

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has been on treatment for more than 24 months

and

☐ Patient's disease has had a complete response to treatment

or

☐ Patient's disease has had a partial response to treatment

or

☐ Patient has stable disease

and

☐ Response to treatment in target lesions has been determined by comparable radiologic or clinical assessment following the most recent treatment period

and

☐ The treatment remains clinically appropriate and the patient is benefitting from the treatment

or

☐ Patient has previously discontinued treatment with nivolumab for reasons other than severe toxicity or disease progression

and

☐ Patient has signs of disease progression

and

☐ Disease has not progressed during previous treatment with nivolumab

Initial application — Renal cell carcinoma

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

☐ Patient is currently on treatment with nivolumab and met all remaining criteria prior to commencing treatment

or

☐ Patient has metastatic renal-cell carcinoma

and

☐ The disease is of predominant clear-cell histology

and

☐ Patient has an ECOG performance score of 0-2

and

☐ Patient has documented disease progression following one or two previous regimens of antiangiogenic therapy

and

☐ Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression

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

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.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Nivolumab *- continued*

Renewal — Renal cell carcinoma

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

Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 4 months.

Prerequisites(tick boxes where appropriate)

- ☐ Patient's disease has had a complete response to treatment

or

- ☐ Patient's disease has had a partial response to treatment

or

- ☐ Patient has stable disease

and

- ☐ No evidence of disease progression

and

- ☐ Nivolumab is to be used as monotherapy at a maximum dose of 240 mg every 2 weeks (or equivalent) and discontinued at disease progression

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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