Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA1986**
April 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: ..... |

## Alglucosidase Alfa

**Initial application**
Applications only from a metabolic physician. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

☐ The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease

**and**

☐ Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells

**or**

☐ Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides

**or**

☐ Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene)

**or**

☐ Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene

**and**

☐ Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT)

**and**

☐ Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT

**and**

☐ Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

**Renewal**

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

Applications only from a metabolic physician. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

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

**and**

☐ Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks

**and**

☐ Patient has not had severe infusion-related adverse reactions which were not preventable by appropriate pre-medication and/or adjustment of infusion rates

**and**

☐ Patient has not developed another life threatening or severe disease where the long term prognosis is unlikely to be influenced by ERT

**and**

☐ Patient has not developed another medical condition that might reasonably be expected to compromise a response to ERT

**and**

☐ There is no evidence of life threatening progression of respiratory disease as evidenced by the needed for > 14 days of invasive ventilation

**and**

☐ There is no evidence of new or progressive cardiomyopathy

**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**