APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2096
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: .....

Casirivimab and imdevimab

Initial application — Treatment of profoundly immunocompromised patients
Applications from any relevant practitioner. Approvals valid for 2 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has confirmed (or probable) COVID-19

and

- ☐ The patient is in the community with mild to moderate disease severity*

and

- ☐ Patient is profoundly immunocompromised** and is at risk of not having mounted an adequate response to vaccination against COVID-19 or is unvaccinated

and

- ☐ Patient's symptoms started within the last 10 days

and

- ☐ Patient is not receiving high flow oxygen or assisted/mechanical ventilation

and

- ☐ Casirivimab and imdevimab is to be administered at a maximum dose of no greater than 2,400 mg

Note: * Mild to moderate disease severity as described on the Ministry of Health Website
** Examples include B-cell depletive illnesses or patients receiving treatment that is B-Cell depleting.

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