Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2266
April 2025

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

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

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First Names: ....

Surname: ....

Address: ....

....

....

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.

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