Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2401
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: .....

Cetuximab

Initial application — head and neck cancer, locally advanced
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck

and

- ☐ Cisplatin is contraindicated or has resulted in intolerable side effects

and

- ☐ Patient has an ECOG performance score of 0-2

and

- ☐ To be administered in combination with radiation therapy

Initial application — colorectal cancer, metastatic
Applications only from a relevant specialist or any relevant practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has metastatic colorectal cancer located on the left side of the colon (see Note)

and

- ☐ There is documentation confirming disease is RAS and BRAF wild-type

and

- ☐ Patient has an ECOG performance score of 0-2

and

- ☐ Patient has not received prior funded treatment with cetuximab

and

- ☐ Cetuximab is to be used in combination with chemotherapy

or

- ☐ Chemotherapy is determined to not be in the best interest of the patient based on clinician assessment

Renewal — colorectal cancer, metastatic

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 6 months.
Prerequisites(tick box where appropriate)

- ☐ There is no evidence of disease progression

Note: Left-sided colorectal cancer comprises of the distal one-third of the transverse colon, the splenic flexure, the descending colon, the sigmoid colon, or the rectum.

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