Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2419
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: .....

Palivizumab

Initial application
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Palivizumab to be administered during the annual RSV season

and

- ☐ Infant was born in the last 12 months

and

- ☐ Infant was born at less than 32 weeks zero days' gestation

or

- ☐ Child was born in the last 24 months

and

- ☐ Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community

or

- ☐ Child has haemodynamically significant heart disease

and

- ☐ Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)

or

- ☐ Child has unoperated or surgically palliated complex congenital heart disease

or

- ☐ Child has severe pulmonary hypertension (see Note C)

or

- ☐ Child has moderate or severe left ventricular (LV) failure (see Note D)

or

- ☐ Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant

or

- ☐ Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

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

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: .....

Palivizumab *- continued*

Renewal

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

- ☐ Palivizumab to be administered during the annual RSV season

and

- ☐ Child was born in the last 24 months

and

- ☐ Child has severe lung, airway, neurological or neuromuscular disease that requires ongoing ventilatory/respiratory support (see Note A) in the community

or

- ☐ Child has haemodynamically significant heart disease

and

- ☐ Child has unoperated simple congenital heart disease with significant left to right shunt (see Note B)

or

- ☐ Child has unoperated or surgically palliated complex congenital heart disease

or

- ☐ Child has severe pulmonary hypertension (see Note C)

or

- ☐ Child has moderate or severe left ventricular (LV) failure (see Note D)

or

- ☐ Child has severe combined immune deficiency, confirmed by an immunologist, but has not received a stem cell transplant

or

- ☐ Child has inborn errors of immunity (see Note E) that increase susceptibility to life-threatening viral respiratory infections, confirmed by an immunologist

Note:

a) Ventilatory/respiratory support includes those on home oxygen, CPAP/VPAP and those with tracheostomies in situ managed at home

b) Child requires/will require heart failure medication, and/or child has significant pulmonary hypertension, and/or infant will require surgical palliation/definitive repair within the next 3 months

c) Mean pulmonary artery pressure more than 25 mmHg

d) LV Ejection Fraction less than 40%

e) Inborn errors of immunity include, but are not limited to, IFNAR deficiencies

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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