Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1492
June 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: .....

Deferasirox

Initial application
Applications only from a haematologist. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has been diagnosed with chronic iron overload due to congenital inherited anaemia

and

- ☐ Deferasirox is to be given at a daily dose not exceeding 40 mg/kg/day

and

- ☐ Treatment with maximum tolerated doses of deferiprone monotherapy or deferiprone and desferrioxamine combination therapy have proven ineffective as measured by serum ferritin levels, liver or cardiac MRI T2*

or

- ☐ Treatment with deferiprone has resulted in severe persistent vomiting or diarrhoea

or

- ☐ Treatment with deferiprone has resulted in arthritis

or

- ☐ Treatment with deferiprone is contraindicated due to a history of agranulocytosis (defined as an absolute neutrophil count (ANC) of < 0.5 cells per µL) or recurrent episodes (greater than 2 episodes) of moderate neutropenia (ANC 0.5 - 1.0 cells per µL)

Renewal

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

Applications only from a haematologist. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ For the first renewal following 2 years of therapy, the treatment has been tolerated and has resulted in clinical improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels

or

- ☐ For subsequent renewals, the treatment has been tolerated and has resulted in clinical stability or continued improvement in all three parameters namely serum ferritin, cardiac MRI T2* and liver MRI T2* levels

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