Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2183**
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: ..... |

## Vedolizumab

**Initial application — Crohn's disease - adults**
Applications from any relevant practitioner. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

☐ Patient has active Crohn's disease

**and**

☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

☐ Patient has a CDAI score of greater than or equal to 300, or HBI score of greater than or equal to 10

**or**

☐ Patient has extensive small intestine disease affecting more than 50 cm of the small intestine

**or**

☐ Patient has evidence of short gut syndrome or would be at risk of short gut syndrome with further bowel resection

**or**

☐ Patient has an ileostomy or colostomy, and has intestinal inflammation

**and**

☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

☐ Immunomodulators and corticosteroids are contraindicated

**Renewal — Crohn's disease - adults**

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

Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick boxes where appropriate)

☐ CDAI score has reduced by 100 points, or HBI score has reduced by 3 points, from when the patient was initiated on biologic therapy

**or**

☐ CDAI score is 150 or less, or HBI is 4 or less

**or**

☐ The patient has experienced an adequate response to treatment, but CDAI score and/or HBI score cannot be assessed

**and**

☐ Vedolizumab to administered at a dose no greater than 300 mg every 8 weeks

**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)

Reg No: .....

Name: .....

Address: .....

.....

.....

Fax Number: .....

**PATIENT** NHI: .....

First Names: .....

Surname: .....

DOB: .....

Address: .....

.....

.....

**REFERRER** Reg No: .....

First Names: .....

Surname: .....

Address: .....

.....

.....

Fax Number: .....

## Vedolizumab *- continued*

**Initial application — Crohn's disease - children***
Applications from any relevant practitioner. Approvals valid for 6 months.
**Prerequisites**(tick boxes where appropriate)

☐ Paediatric patient has active Crohn's disease

**and**

☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

☐ Patient has a Paediatric Crohn's Disease Activity Index (PCDAI) score of greater than or equal to 30

**or**

☐ Patient has extensive small intestine disease

**and**

☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

☐ Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with * is an unapproved indication.

**Renewal — Crohn's disease - children***

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

Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick boxes where appropriate)

☐ PCDAI score has reduced by 10 points from when the patient was initiated on biologic therapy

**or**

☐ PCDAI score is 15 or less

**or**

☐ The patient has experienced an adequate response to treatment, but CDAI score cannot be assessed

**and**

☐ Vedolizumab to administered at a dose no greater than 300mg every 8 weeks

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.**

Signed: ..... Date: .....

**Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**

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| ..... | ..... | ..... |
| Fax Number: ..... | ..... | Fax Number: ..... |

## Vedolizumab *- continued*

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

- ☐ Patient has active ulcerative colitis

**and**

- ☐ Patient has had an initial approval for prior biologic therapy and has experienced intolerable side effects or insufficient benefit to meet renewal criteria (unless contraindicated)

**or**

- ☐ Patient has a SCCAI score is greater than or equal to 4

**or**

- ☐ Patient's PUCAI score is greater than or equal to 20*

**and**

- ☐ Patient has tried but experienced an inadequate response to (including lack of initial response and/or loss of initial response) from prior therapy with immunomodulators and corticosteroids

**or**

- ☐ Patient has experienced intolerable side effects from immunomodulators and corticosteroids

**or**

- ☐ Immunomodulators and corticosteroids are contraindicated

Note: Indication marked with * is an unapproved indication.

**Renewal — ulcerative colitis**

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

Applications from any relevant practitioner. Approvals valid for 2 years.
**Prerequisites**(tick boxes where appropriate)

- ☐ The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy

**or**

- ☐ The PUCAI score has reduced by 10 points or more from the PUCAI score since initiation on biologic therapy *

**and**

- ☐ Vedolizumab will be used at a dose no greater than 300 mg intravenously every 8 weeks

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.**

Signed: ..... Date: .....
**Post application to Ministry of Health, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz**