Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2325
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: .....

Niraparib

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

- ☐ Patient has advanced high-grade serous* epithelial ovarian, fallopian tube, or primary peritoneal cancer
- **and** ☐ Patient has received at least one line** of treatment with platinum-based chemotherapy
- **and** ☐ Patient has experienced a partial or complete response to the preceding treatment with platinum-based chemotherapy
- **and** ☐ Patient has not previously received funded treatment with a PARP inhibitor
- **and**
  - ☐ Treatment will be commenced within 12 weeks of the patient's last dose of the preceding platinum-based regimen
  - **or** ☐ Patient commenced treatment with niraparib prior to 1 May 2024
- **and** ☐ Treatment to be administered as maintenance treatment
- **and** ☐ Treatment not to be administered in combination with other chemotherapy

Renewal

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

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

- ☐ No evidence of progressive disease
- **and** ☐ Treatment to be administered as maintenance treatment
- **and** ☐ Treatment not to be administered in combination with other chemotherapy
- **and**
  - ☐ Treatment with niraparib to cease after a total duration of 36 months from commencement
  - **or** ☐ Treatment with niraparib is being used in the second-line or later maintenance setting

Note: * "high-grade serous" includes tumours with high-grade serous features or a high-grade serous component.
**A line of chemotherapy treatment is considered to comprise a known standard therapeutic chemotherapy regimen and supportive treatments

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