# SPECIAL AUTHORITY FORMS June 2025

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#### THE SPECIAL AUTHORITY SYSTEM

Special Authority is an application process in which a prescriber requests government subsidy for a particular person.

#### Criteria

The criteria for approval of Special Authority applications are included below each pharmaceutical listing. For some Special Authority pharmaceuticals, not all indications listed on the data sheets are subsidised. Criteria for each Special Authority pharmaceutical are updated regularly, based on the decision criteria of Pharmac. The appropriateness of the listing of a pharmaceutical in the Special Authority category will also be regularly reviewed. Applications for inclusion of further pharmaceuticals in the Special Authority category will generally be made by a pharmaceutical supplier.

#### **Applications from Specialists**

"Specialist" means, a doctor who holds a current annual practising certificate and who satisfies the criteria set out below.

- a. The doctor's name appears in the Vocational Register of medical practitioners in accordance with Section 21 and 22 of the Medical Practitioners Act 1995 and who is making the application in the course of practising in that area of medicine; and the doctor's vocational branch or sub-branch is one of those listed below:
  - anaesthetics
  - cardiothoracic surgery
  - dermatology
  - diagnostic radiology
  - emergency medicine
  - general surgery
  - internal medicine
  - neurosurgery
  - · obstetrics and gynaecology
  - occupational medicine
  - ophthalmology
  - otolaryngology head and neck surgery
  - orthopaedic surgery
  - paediatric surgery
  - paediatrics
  - pathology
  - plastic and reconstructive surgery
  - psychological medicine or psychiatry
  - public health medicine
  - · radiation oncology
  - · rehabilitation medicine
  - urology and venereology
- b. The doctor is recognised by the Ministry of Health as a specialist for the purposes of the Pharmaceutical Schedule and receives remuneration from a Health NZ Hospital at a level which that Health NZ Hospital considers appropriate for specialists and who has written that Prescription in the course of practising in that area of medicine
- c. The doctor is recognised by the Ministry of Health as a specialist in relation to a particular area of medicine for the purpose of writing Prescriptions and who has written the Prescription in the course of practising in that area of medicine.
- d. The doctor writes the Prescription on Health NZ Hospital stationery and is appropriately authorised by the relevant Health NZ Hospital to do so.

#### **Approval**

Special Authority applications are administered by the Ministry of Health. They were formerly administered by Health Payments, Agreements and Compliance (HealthPAC), a division of the Ministry of Health. All applications should be sent, in writing, to:

Ministry of Health, Private Bag 3015, WANGANUI

customerservice@health.govt.nz

For inquiries, please call the Contact Centre on, free phone 0800 243 666

Each application must include:

- name and date of birth of the patient (codes for AIDS patients' applications)
- · diagnosis and brief clinical details
- name of the medicine required, the form and strength of the medicine
- duration of the course of treatment
- alternative therapies that have been tried

#### The application must:

- be signed by the practitioner
- include the practitioner's printed name and address
- show the practitioner's Medical Council registration number
- provide evidence of the criteria as per Special Authority conditions for medicine applied for

#### Subsidy

Once approved, health providers can obtain the Special Authority approval details for prescribing and dispensing purposes by calling the Contact Centre on 0800 243 666

Specialists who make an application must communicate the valid authority number to the prescriber who will be writing the prescriptions.

The authority number can provide access to subsidy, additional subsidy, or waive certain restrictions otherwise present on the pharmaceutical. Some approvals are dependent on the availability of funding.

Panel Approvals

Access to subsidy for the following products must be approved by a panel of clinicians
Applications to be made on the approved forms which are available from the co-ordinator:

Panel Co-ordinator

Pharmac

PO Box 10 254 Wellington
Phone: 04 460 4990 Facsimile: 04 460 4995
E-mail: ECPanel@Pharmac.govt.nz

Product (Form No)	Panel
, ,	PHARMAC
Ledipasvir with sofosbuvir (SA1605)	

**Alimentary Tract and Metabolism** 

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 6 Form SA1886 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:
		Tax Number
Budesonide - Cap 3 mg Controlled Rel	ease	
or History of severe psychiatric or History of major mental illne relapse is considered to be	or proximal Crohn's disease  significant risk of fracture  ment with conventional corticosteroid therapy  problems associated with corticosteroid treatment  ss (such as bipolar affective disorder) where the risk	
Initial application — collagenous and lymphoc Applications from any relevant practitioner. Appropriet Prerequisites (tick box where appropriate)  Patient has a diagnosis of microscopic of the property of th		opy with biopsies
Initial application — gut Graft versus Host dise Applications from any relevant practitioner. Appro-		
Prerequisites(tick box where appropriate)		
Patient has a gut Graft versus Host diseance: Indication marked with * is an unapproved in	ase following allogenic bone marrow transplantation*	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 7 Form SA1886 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:
Budesonide - Cap 3 mg Controlled Rel	ease - continued	
or History of severe psychiatric or History of major mental illne	significant risk of fracture nent with conventional corticosteroid therapy problems associated with corticosteroid treatment ss (such as bipolar affective disorder) where the risk	of conventional corticosteroid treatment causing
or Relapse during pregnancy (	nigh where conventional corticosteroids are considered to	he contraindicated)
or	growth (where conventional corticosteroid use may I	
		initial title growth
Note: Indication marked with * is an unapproved in	ndication.	
Renewal Current approval Number (if known):	vals valid for 6 months.	
Renewal — non-cirrhotic autoimmune hepatitis	3	
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid for 6 months.	
The treatment remains appropriate and t	he patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 8 Form SA1329 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:
Glyceryl trinitrate Oint 0.2%		
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick box where appropriate)	rals valid without further renewal unless notified.	
The patient has a chronic anal fissure that has persisted for longer than three weeks		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 9 Form SA1461 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:
Rifaximin		
Initial application Applications only from a gastroenterologist, hepato for 6 months.  Prerequisites(tick box where appropriate)	logist or Practitioner on the recommendation of a gas	stroenterologist or hepatologist. Approvals valid
The patient has hepatic encephalopathy	despite an adequate trial of maximum tolerated dose	s of lactulose
Renewal		
Current approval Number (if known):		
Applications only from a gastroenterologist, hepato without further renewal unless notified. <b>Prerequisites</b> (tick box where appropriate)	logist or Practitioner on the recommendation of a gas	stroenterologist or hepatologist. Approvals valid
The treatment remains appropriate and the	ne patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 10 Form SA1320 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:
Diazoxide		
Initial application Applications from any relevant practitioner. Approx Prerequisites(tick box where appropriate)		
Used for the treatment of confirmed hypo	oglycaemia caused by hyperinsulinism	
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid without further renewal unless notified.	
The treatment remains appropriate and t	he patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 11 Form SA2440

		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:
	less) has not been achieved despite the regular use of the state of th	
Patient has pre-existing card Patient has an absolute 5-ye assessment calculator*	liovascular disease or risk equivalent (see note a)* ear cardiovascular disease risk of 15% or greater accordiovascular risk due to being diagnosed with type 2 disease (see note b)*	
Note: * Criteria intended to describe patients at high	gh risk of cardiovascular or renal complications of dia	betes.
	ivalent defined as: prior cardiovascular disease even grafting, transient ischaemic attack, ischaemic stroke	
,	albuminuria (albumin:creatinine ratio greater than or R less than 60 mL/min/1.73m2 in the presence of diab	,
	combination with (empagliflozin /empagliflozin with m with metformin hydrochloride) for the treatment of hea	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 12 Form SA2408 June 2025

APPLICANT (stamp or sticker accepta	able) PATIENT NHI:	REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Empagliflozin; Empagliflozin	with metformin hydrochloride	
Initial application — heart failure re Applications from any relevant practit Prerequisites(tick boxes where appr	oner. Approvals valid without further renewal u	nless notified.
Patient has heart failu	ire	
	nctional class II or III or IV	
and Patient has a d	ocumented left ventricular ejection fraction (LVE	EF) of less than or equal to 40%
or An ECHO is no	t reasonably practicable, and in the opinion of t	he treating practitioner the patient would benefit from treatment
and		
Patient is receiving co	oncomitant optimal standard funded chronic hea	art failure treatment
Prerequisites (tick boxes where appropriate or Patient has previously or Patient has type and Patient has type and Patient hor Patient h	received an initial approval for a GLP-1 agonis e 2 diabetes  Māori or any Pacific ethnicity* as pre-existing cardiovascular disease or risk ed as an absolute 5-year cardiovascular disease rient calculator* as a high lifetime cardiovascular risk due to beir ult* as diabetic kidney disease (see note b)*	quivalent (see note a)* sk of 15% or greater according to a validated cardiovascular risk ng diagnosed with type 2 diabetes during childhood or as a  despite the regular use of at least one blood-glucose lowering
Note: * Criteria intended to describe	patients at high risk of cardiovascular or renal co	omplications of diabetes.
	tery bypass grafting, transient ischaemic attack	cular disease event (i.e. angina, myocardial infarction, percutaneous , ischaemic stroke, peripheral vascular disease), congestive heart
		tio greater than or equal to 3 mg/mmol, in at least two out of three ne presence of diabetes, without alternative cause.
	zin with metformin hydrochloride] treatment is r metformin hydrochloride] for the treatment of h	not to be given in combination with a funded GLP-1 unless receiving eart failure.

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 13 Form SA2367 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:
Insulin pump with algorithm		
or  The patient has Type 3c dial deficiency due to pancreated or  The patient has atypical inherence and  Patient has been evaluated by a dand	neonatal diabetes or specific monogenic diabetes sul kely to benefit petes considered by the treating endocrinologist as li ctomy, insulin deficiency secondary to cystic fibrosis o	kely to benefit (Type 3c diabetes includes insulin or pancreatitis)
Renewal — type 1 diabetes		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvemental Prerequisites (tick box where appropriate)	als valid for 6 months.	
The patient is continuing to derive benefi	t according to the treatment plan agreed at induction	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 14 Form SA2380 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:
Insulin Pump Consumables		
or  The patient has Type 3c dial deficiency due to pancreated or  The patient has atypical inherence and  Patient has been evaluated by a dand	neonatal diabetes or specific monogenic diabetes sul kely to benefit petes considered by the treating endocrinologist as li ctomy, insulin deficiency secondary to cystic fibrosis of	kely to benefit (Type 3c diabetes includes insulin or pancreatitis)
Renewal — type 1 diabetes		
Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)		
The natient is continuing to derive benefi	t according to the treatment plan agreed at induction	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 15 Form SA2370 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:
Continuous glucose monitor (standalo	ne)	
or treating endocrinologist or relevant	tal diabetes or specific monogenic diabetes subtypes t secondary health care professional as practicable, a considered by the treating endocrinologist or relevant be 3c diabetes includes insulin deficiency due to pand	as likely to benefit secondary health care professional as
Renewal — type 1 diabetes  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)		
The patient is continuing to derive benefi	t according to the treatment plan agreed at induction	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 16 Form SA2371 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:	rable)	Fax Number:
Initial application — type 1 diabetes Applications from any relevant practitioner. Approve Prerequisites(tick boxes where appropriate)	als valid for 1 year.	
The patient has type 1 diabetes  The patient has permanent neonatal diabetes or specific monogenic diabetes subtypes with insulin deficiency, considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit  The patient has Type 3c diabetes considered by the treating endocrinologist or relevant secondary health care professional as practicable, as likely to benefit (Type 3c diabetes includes insulin deficiency due to pancreatectomy, insulin deficiency secondary to cystic fibrosis or pancreatitis)  The patient has atypical inherited forms of diabetes  and  In the opinion of the treating relevant practitioner the patient would benefit from an Automated Insulin Delivery (AID) system		
Renewal — type 1 diabetes  Current approval Number (if known):		

#### SA2448 - Ursodeoxycholic Acid

Alagille syndrome or progressive familial intrahepatic cholestasis - Initial application	
Chronic severe drug induced cholestatic liver injury - Initial application	
Haematological Transplant - Initial application	18
Pregnancy - Initial application	18
Pregnancy/Primary biliary cholangitis - Renewal	19
Primary biliary cholangitis - Initial application	18
Total parenteral nutrition induced cholestasis - Initial application	19
Total parenteral nutrition induced cholestasis - Renewal	19
Prevention of sinusoidal obstruction syndrome - Initial application	19
• • • • • • • • • • • • • • • • • • • •	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 18 Form SA2448 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:	
Ursodeoxycholic Acid			
Initial application — Alagille syndrome or prographications from any relevant practitioner. Appropriates (tick boxes where appropriate)  Patient has been diagnosed with a prographic femilial in	ovals valid without further renewal unless notified.  Alagille syndrome		
Patient has progressive familial in	tranepatic cholestasis		
Initial application — Chronic severe drug induced cholestatic liver injury Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)			
Patient has chronic severe drug induced cholestatic liver injury  and Cholestatic liver injury not due to Total Parenteral Nutrition (TPN) use in adults  and Treatment with ursodeoxycholic acid may prevent hospital admission or reduce duration of stay			
Initial application — Primary biliary cholangitis Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)			
Primary biliary cholangitis confirmed by antimitochondrial antibody titre (AMA) > 1:80, and raised cholestatic liver enzymes with or without raised serum IgM or, if AMA is negative, by liver biopsy			
Patient not requiring a liver transplant (bilirubin > 100 umol/l; decompensated cirrhosis)			
Initial application — Pregnancy Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  The patient diagnosed with cholestasis of pregnancy			
Initial application — Haematological Transplan Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)	nt ovals valid for 6 months.		
Patient at risk of veno-occlusive d or bone marrow transplantation and	isease or has hepatic impairment and is undergoing o	conditioning treatment prior to allogenic stem cell	
Treatment for up to 13 weeks			

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 19 Form SA2448 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:
Ursodeoxycholic Acid - continued		
Initial application — Total parenteral nutrition i Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
Paediatric patient has developed a (TPN)  and  Liver function has not improved wi	abnormal liver function as indicated on testing which i	s likely to be induced by Total Parenteral Nutrition
Renewal — Chronic severe drug induced chole	estatic liver injury	
Current approval Number (if known):		
Applications from any relevant practitioner. Appro- Prerequisites(tick box where appropriate)		
The patient continues to benefit from treations.	atment	
Renewal — Pregnancy/Primary biliary cholang	itis	
Current approval Number (if known):		
Applications from any relevant practitioner. Appro- Prerequisites(tick box where appropriate)	vals valid for 2 years.	
The treatment remains appropriate and to	the patient is benefiting from treatment	
Renewal — Total parenteral nutrition induced of	cholestasis	
Current approval Number (if known):		
Applications from any relevant practitioner. Appro-		
Prerequisites(tick box where appropriate)		
The paediatric patient continues to requi	re TPN and who is benefiting from treatment, defined	as a sustained improvement in bilirubin levels
Initial application — prevention of sinusoidal of Applications from any relevant practitioner. Appropries (tick box where appropriate)		
The individual has leukaemia/lymphoma	and requires prophylaxis for medications/therapies v	with a high risk of sinusoidal obstruction syndrome

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 20 Form SA1691 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:	
Methylnaltrexone bromide			
Initial application — Opioid induced constipation Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)			
The patient is receiving palliative care			
Oral and rectal treatments for opioid induced constipation are ineffective			
Oral and rectal treatments for	r opioid induced constipation are unable to be tolera	ted	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 21 **Form SA2053** 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:
Sodium picosulfate		
Application Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  The patient is a child with problematic constipation despite an adequate trial of other oral pharmacotherapies including macrogol where practicable  and  The patient would otherwise require a high-volume bowel cleansing preparation or hospital admission		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv <b>Prerequisites</b> (tick box where appropriate)	als valid for 12 months.	
The treatment remains appropriate and the	ne patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 22 Form SA1988 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:	
Galsulfase			
Initial application Applications only from a metabolic physician. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has been diagnosed with mucopolysaccharidosis VI  and  Diagnosis confirmed by demonstration of N-acetyl-galactosamine-4-sulfatase (arylsulfatase B) deficiency by either enzyme activity assay in leukocytes or skin fibroblasts  or  Detection of two disease causing mutations and patient has a sibling who is known to have mucopolysaccharidosis VI			
Renewal Current approval Number (if known): Applications only from a metabolic physician. Appr Prerequisites (tick boxes where appropriate)			
Patient has not had severe infusion adjustment of infusion rates  and Patient has not developed another Enzyme Replacement Therapy (EF	for the patient and the patient is benefiting from treateristics adverse reactions which were not preventable life threatening or severe disease where the long terms (RT)	ole by appropriate pre-medication and/or m prognosis is unlikely to be influenced by	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 23 Form SA1990 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:
Sodium phenylbutyrate		
Initial application Applications only from a metabolic physician. Appl Prerequisites(tick box where appropriate)	rovals valid for 12 months.	
The patient has a diagnosis of a urea cyc argininosuccinate synthetase	ele disorder involving a deficiency of carbamylphosph	ate synthetase, ornithine transcarbamylase or
Renewal		
Current approval Number (if known):		
Applications only from a metabolic physician. Applications only from a metabolic physician. Applications only from a metabolic physician.	ovals valid for 12 months.	
The treatment remains appropriate and the	ne patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 24 Form SA1599 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:
Sodium benzoate		
Initial application Applications only from a metabolic physician. Approvals valid for 12 months.  Prerequisites(tick box where appropriate)		
The patient has a diagnosis of a urea cyc	cle disorder	
Renewal		
Current approval Number (if known):		
Applications only from a metabolic physician. App <b>Prerequisites</b> (tick box where appropriate)	rovals valid for 12 months.	
The treatment remains appropriate and t	he patient is benefiting from treatment	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 25 Form SA1986 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:
Alglucosidase Alfa		
Initial application Applications only from a metabolic physician. Application only from a metabolic physician. Application only from a metabolic physician. Application only from a metabolic physician. Applications only from a metabolic physician. Application only from a metabolic physician. Applications only from a metabolic physician only from a metabolic physician.		nosed with infantile Pompe disease
The patient is aged up to 24 months at the time of initial application and has been diagnosed with infantile Pompe disease    Diagnosis confirmed by documented deficiency of acid alpha-glucosidase by prenatal diagnosis using chorionic villus biopsies and/or cultured amniotic cells   Documented deficiency of acid alpha-glucosidase, and urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides   Documented deficiency of acid alpha-glucosidase, and documented molecular genetic testing indicating a disease-causing mutation in the acid alpha-glucosidase gene (GAA gene)   Documented urinary tetrasaccharide testing indicating a diagnostic elevation of glucose tetrasaccharides, and molecular genetic testing indicating a disease-causing mutation in the GAA gene   Patient has not required long-term invasive ventilation for respiratory failure prior to starting enzyme replacement therapy (ERT)   Patient does not have another life-threatening or severe disease where the prognosis is unlikely to be influenced by ERT or might be reasonably expected to compromise a response to ERT   Alglucosidase alfa to be administered at doses no greater than 20 mg/kg every 2 weeks		
and Alglucosidase alfa to be administer and Patient has not had severe infusior adjustment of infusion rates and Patient has not developed another and Patient has not developed another and		ble by appropriate pre-medication and/or m prognosis is unlikely to be influenced by ERT d to compromise a response to ERT
There is no evidence of new or pro	gressive cardiomyopathy	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 26 Form SA1623 June 2025

APPLICAI	NT (s	tamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:			Surname:	Surname:
Address: .			DOB:	Address:
			Address:	
Fax Numb	er:			Fax Number:
ldursulfa	ase			
	sites	nly from a metabolic physician. Approfice (tick boxes where appropriate)  The patient has been diagnosed w	ith Hunter Syndrome (mucopolysaccharidosis II)	
	or	skin fibroblasts	onstration of iduronate 2-sulfatase deficiency in white ng mutation in the iduronate 2-sulfatase gene	e blood cells by either enzyme assay in cultured
and	and Patient is going to proceed with a haematopoietic stem cell transplant (HSCT) within the next 3 months and treatment with idursulfase would be bridging treatment to transplant			
and		Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT)		
and		Idursulfase to be administered for a 0.5 mg/kg every week	a total of 24 weeks (equivalent to 12 weeks pre- and	12 weeks post-HSCT) at doses no greater than

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 27 Form SA1695 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:	
Laronidase			
and  Diagnosis confirmed by dem skin fibroblasts  or  Detection of two disease cau Hurler syndrome	ith Hurler Syndrome (mucopolysacchardosis I-H) onstration of alpha-L-iduronidase deficiency in white I	patient has a sibling who is known to have	
would be bridging treatment to tran	•		
Patient has not required long-term	Patient has not required long-term invasive ventilation for respiratory failure prior to starting Enzyme Replacement Therapy (ERT) and		
Laronidase to be administered for a total of 24 weeks (equivalent to 12 weeks pre- and 12 post-HSCT) at doses no greater than 100 units/kg every week		12 post-HSCT) at doses no greater than	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 28 Form SA1987 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:	
Betaine			
Initial application Applications only from a metabolic physician. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has a confirmed diagnosis of homocystinuria  and  A cystathionine beta-synthase (CBS) deficiency  or  A 5,10-methylene-tetrahydrofolate reductase (MTHFR) deficiency  or  A disorder of intracellular cobalamin metabolism  and  An appropriate homocysteine level has not been achieved despite a sufficient trial of appropriate vitamin supplementation			
Renewal  Current approval Number (if known):			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 29 Form SA1989 June 2025

APPLICANT (stamp or sticker acceptable)		mp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Addre	ss:			DOB:	Address:
				Address:	
			ihydrochloride		Fax Number:
Appli	Initial application Applications only from a metabolic physician. Approvals valid for 1 month.  Prerequisites(tick boxes where appropriate)  Patient has phenylketonuria (PKU) and is pregnant or actively planning to become pregnant  Treatment with sapropterin is required to support management of PKU during pregnancy  and  Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg  and  Sapropterin to be used alone or in combination with PKU dietary management  and  Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and becoming pregnant) and treatment will be stopped after delivery				
Renewal  Current approval Number (if known):					
		or	with a clinically appropriate  On subsequent renewal appropriate	nth approval, the patient has demonstrated an adequated reduction in phenylalanine levels to support manager plications, the patient has previously demonstrated reallalanine levels to support management of PKU during	nent of PKU during pregnancy sponse to treatment with sapropterin and
	and	or or	Patient is actively planning	gnant and treatment with sapropterin will not continue a pregnancy and this is the first renewal for treatment is required for a second or subsequent pregnancy to s	with sapropterin
and Sapropterin to be administered at doses no greater than a total daily dose of 20 mg/kg and Sapropterin to be used alone or in combination with PKU dietary management and Total treatment duration with sapropterin will not exceed 22 months for each pregnancy (includes time for planning and bed pregnant) and treatment will be stopped after delivery					
		(includes time for planning and becoming			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 30 Form SA2039 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:	
Coenzyme Q10			
Initial application Applications only from a metabolic physician. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)			
Patient has a suspected inborn error of metabolism that may respond to coenzyme Q10 supplementation			
Renewal			
Current approval Number (if known):			
Applications only from a metabolic physician. Approvals valid for 24 months.  Prerequisites(tick boxes where appropriate)			
The patient has a confirmed diagn	osis of an inborn error of metabolism that responds to	o coenzyme Q10 supplementation	
	and the patient is benefiting from treatment		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 31 Form SA2040 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:		
Levocarnitine				
Initial application Applications only from a metabolic physician. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  Patient has a suspected inborn error of metabolism that may respond to carnitine supplementation				
Renewal				
Current approval Number (if known):				
Applications only from a metabolic physician. Approvals valid for 24 months.  Prerequisites(tick boxes where appropriate)				
The patient has a confirmed diagno	The patient has a confirmed diagnosis of an inborn error of metabolism that responds to carnitine supplementation			
The treatment remains appropriate and the patient is benefiting from treatment				

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 32 Form SA2041 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:	
Riboflavin			
Initial application Applications only from a metabolic physician or neurologist. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  Patient has a suspected inborn error of metabolism that may respond to riboflavin supplementation			
Renewal  Current approval Number (if known):			
and	osis of an inborn error of metabolism that responds to	o riboflavin supplementation	
The treatment remains appropriate and the patient is benefiting from treatment			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 33 Form SA2042 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:	
Arginine			
Initial application Applications only from a metabolic physician. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  Patient has a suspected inborn error of metabolism that may respond to arginine supplementation			
Renewal			
Current approval Number (if known):			
Applications only from a metabolic physician. Approvals valid for 24 months.  Prerequisites(tick boxes where appropriate)			
	osis of an inborn error of metabolism that responds to	arginine supplementation	
The treatment remains appropriate	and the patient is benefiting from treatment		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 34 Form SA2043 June 2025

APPL	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	0:	First Names:	First Names:
Name		Surname:	Surname:
Addre	SS:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Tauri	ne		
Initial application Applications only from a metabolic physician. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  Patient has a suspected specific mitochondrial disorder that may respond taurine supplementation			
Renewal  Current approval Number (if known):			
The patient has confirmed diagnosis of a specific mitochondrial disorder which responds to taurine supplementation and  The treatment remains appropriate and the patient is benefiting from treatment			s to taurine supplementation

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 35 Form SA2324 June 2025

APPL	ICANT (st	tamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	o:		First Names:	First Names:	
Name	:		Surname:	Surname:	
Addre	ss:		DOB:	Address:	
			Address:		
Fax N	umber:			Fax Number:	
Trien	tine				
Appli	Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
	and	Patient has confirmed Wilson disea	ase		
and		Treatment with D-penicillamine has been trialled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit			
		Treatment with zinc has been trailled and discontinued because the person has experienced intolerable side effects or has not received sufficient benefit, or zinc is considered clinically inappropriate as the person has symptomatic liver disease and requires copper chelation			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 36 Form SA2137 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:		
Initial application Applications only from a metabolic physician. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has a diagnosis of symptomatic type 1 or type 3* Gaucher disease confirmed by the demonstration of specific deficiency of				
and Patient does not have another life-	or cultured skin fibroblasts, and genotypic analysis threatening or severe disease where the prognosis is to be reasonably expected to compromise a response			
Patient has haematological complications of Gaucher disease  or Patient has skeletal complications of Gaucher disease  or Patient has significant liver dysfunction or hepatomegaly attributable to Gaucher disease  or Patient has reduced vital capacity from clinically significant or progressive pulmonary disease due to Gaucher disease  or Patient is a child and has experienced growth failure with significant decrease in percentile linear growth over a 6-12 month period  and Taliglucerase alfa is to be administered at a dose no greater than 30 unit/kg every other week rounded to the nearest whole vial (200 units)				
Note: Indication marked with * is an unapproved in	Note: Indication marked with * is an unapproved indication			
Renewal  Current approval Number (if known):				
and Patient has demonstrated a clinical spleen size and Radiological (MRI) signs of bone a deterioration shown by the MRI, co	omatic improvement and has maintained improvement or no deterioration in haem ctivity performed at two years since initiation of treatrompared with MRI taken immediately prior to commer medical condition that might reasonably be expected	noglobin levels, platelet counts and liver and ment, and five yearly thereafter, demonstrate no neement of therapy or adjusted dose		
and	atment and taliglucerase alfa is to be administered at			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 37 Form SA1720 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:
Vitabdeck		
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	als valid without further renewal unless notified.	7
Patient has cystic fibrosis with pane	creatic insufficiency	
Patient is an infant or child with live	er disease or short gut syndrome	
Patient has severe malabsorption s	syndrome	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 38 Form SA1036 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:
Multivitamins (Paediatric Seravit)		
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient has inborn errors of metabolism		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	rals valid without further renewal unless notified.	
Patient has had a previous approval for multivitamins		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 39 Form SA1546 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:
Multivitamin renal (Clinicians Renal Vit)		
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)		
The patient has chronic kidney dis	ease and is receiving either peritoneal dialysis or hae	emodialysis
	ease grade 5, defined as patient with an estimated gl	omerular filtration rate of < 15 ml/min/1.73 m <sup>2</sup>
L		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 40 Form SA2394 June 2025

APPL	ICAN	T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	No:		First Names:	First Names:
Name	e:		Surname:	Surname:
Addre	ess:		DOB:	Address:
			Address:	
Fax N	lumber	r		Fax Number:
Ferri	ic car	rboxymaltose		
Appl	ication	lication — Anaemia s from any relevant practitioner. Appro ites(tick boxes where appropriate)	vals valid for 3 months.	
	and	Patient has been diagnosed with a	anaemia	
	Serum ferritin level is 20 mcg/L or less			
	Serum ferritin is between 20 and 50 mcg/L and			
	C-Reactive Protein (CRP) is at least 5 mg/L			
	Patient has chronic inflammatory disease with symptoms of anaemia despite normal iron levels			
	Oral iron treatment has proven ineffective or			
	Oral iron treatment has resulted in dose-limiting intolerance			
	Rapid correction of anaemia is required			
_				
		<ul><li>Anaemia</li><li>proval Number (if known):</li></ul>		
Appl	ication	is from any relevant practitioner. Approites(tick boxes where appropriate)		
	and		a with a serum ferritin level of 20 mcg/L, or less or be ry disease with symptoms of anaemia despite norma	
	[	A trial (or re-trial) with oral iron is o	clinically inappropriate	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 41 Form SA2394 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:  Ferric carboxymaltose - continued		Fax Number:
	cian, obstetrician, gynaecologist, anaesthetist or medi ologist or anaesthetist. Approvals valid for 3 months.	cal practitioner on the recommendation of a
Patient has been diagnosed with	iron-deficiency anaemia	
Patient has been compliant with oral iron treatment and treatment has proven ineffective or		
Treatment with oral iron has	s resulted in dose-limiting intolerance	
Patient has symptomatic heart failure, chronic kidney disease stage 3 or more or active inflammatory bowel disease and a trial of oral iron is unlikely to be effective		
Rapid correction of anaemi	a is required	
Renewal — iron deficiency anaemia		
Current approval Number (if known):		
Applications only from an internal medicine physician, obstetrician, gynaecologist, anaesthetist or medical practitioner on the recommendation of a internal medicine physician, obstetrician, gynaecologist or anaesthetist. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)		
	Patient continues to have iron-deficiency anaemia	
and A re-trial with oral iron is clinically inappropriate		

**Blood and Blood Forming Organs** 

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 43 Form SA2266 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:
Hypoplastic and Haemolytic		
Initial application — chronic renal failure Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	als valid for 2 years.	
Patient in chronic renal failure and Haemoglobin is less than or equal	to 100a/L	
and	10 100g/E	
Patient does not have	diabetes mellitus	
	te is less than or equal to 30ml/min	
or		
Patient has diabetes mellitus		
Glomerular filtration rate is less than or equal to 45ml/min		
or Patient is on haemodialysis or peritoneal dialysis		
Initial application — myelodysplasia Applications from any specialist. Approvals valid for Prerequisites(tick boxes where appropriate)	or 2 months.	
Patient has a confirmed diagnosis	of myelodysplasia (MDS)*	
and	h haemoglobin < 100g/L and is red cell transfusion-d	ependent
and	ediate risk MDS based on the WHO classification based	
and	R12 and folate deficiency have been excluded	
Other causes of anaemia such as B12 and folate deficiency have been excluded  and  Deficient has a corresponding level of a 500 H//		
Patient has a serum epoetin level of < 500 IU/L  and		
The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week		
Note: Indication marked with * is an unapproved in	dication	
Renewal — chronic renal failure		
Current approval Number (if known):  Applications from any relevant practitioner. Approv		
Prerequisites(tick box where appropriate)	•	
The treatment remains appropriate and t	he patient is benefiting from treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 44 Form SA2266 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:
Hypoplastic and Haemolytic - continued		
Renewal — myelodysplasia		
Current approval Number (if known):		
Applications from any specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)		
Transfer and the second of the		
The patient's transfusion requirement	ent continues to be reduced with erythropoietin treatm	nent
Transformation to acute myeloid leukaemia has not occurred		
The minimum necessary dose of epoetin would be used and will not exceed 80,000 iu per week		
Note: Indication marked with * is an unapproved in	dication	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 45 Form SA1743 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:
Eltrombopag		
Initial application — idiopathic thrombocytop Applications only from a haematologist. Approve Prerequisites(tick boxes where appropriate)		
Patient has had a splenectomy		
	es have been trialled and failed after therapy of 3 mont	ths each (or 1 month for rituximab)
	nt of 20,000 to 30,000 platelets per microlitre and has e	vidence of significant mucocutaneous bleeding
Patient has a platelet cour	nt of less than or equal to 20,000 platelets per microlitre	e and has evidence of active bleeding
Patient has a platelet cour	nt of less than or equal to 10,000 platelets per microlitre	
Initial application — idiopathic thrombocytop Applications only from a haematologist. Approve Prerequisites(tick box where appropriate)  The patient requires eltrombopag treat	als valid for 6 weeks.	
The patient requires enformbopay freat	ment as preparation for spieriectomy	
Initial application — idiopathic thrombocytop Applications only from a haematologist. Approve Prerequisites(tick boxes where appropriate)	penic purpura contraindicated to splenectomy als valid for 3 months.	
Patient has a significant and wel	l-documented contraindication to splenectomy for clinic	cal reasons
	es have been trialled and failed after therapy of 3 mont	ths each (or 1 month for rituximab)
Patient has immune throm	abocytopenic purpura* with a platelet count of less than	or equal to 20,000 platelets per microliter
	bocytopenic purpura* with a platelet count of 20,000 to	o 30,000 platelets per microlitre and significant
Initial application — severe aplastic anaemia Applications only from a haematologist. Approva Prerequisites(tick boxes where appropriate)	als valid for 3 months.	
· ·	es have been trialled and failed after therapy of at leas	t 3 months duration
Patient has severe aplastic	c anaemia with a platelet count of less than or equal to	20,000 platelets per microliter
Patient has severe aplastic bleeding	c anaemia with a platelet count of 20,000 to 30,000 plat	telets per microlitre and significant mucocutaneous

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 46 Form SA1743 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:	
Eltrombopag - continued			
Renewal — idiopathic thrombocytopenic purpu	ra - post-splenectomy		
Current approval Number (if known):			
Applications only from a haematologist. Approvals <b>Prerequisites</b> (tick box where appropriate)			
The patient has obtained a response (see Note) from treatment during the initial approval or subsequent renewal periods and further treatment is required  Note: Response to treatment is defined as a platelet count of > 30,000 platelets per microlitre.  Renewal — idiopathic thrombocytopenic purpura contraindicated to splenectomy			
Current approval Number (if known):			
Applications only from a haematologist. Approvals <b>Prerequisites</b> (tick boxes where appropriate)	valid for 12 months.		
The patient's significant contraindic	cation to splenectomy remains		
The patient has obtained a respon	se from treatment during the initial approval period		
Patient has maintained a platelet count of at least 50,000 platelets per microlitre on treatment			
Further treatment with eltrombopa	g is required to maintain response		
Renewal — severe aplastic anaemia			
Current approval Number (if known):			
Applications only from a haematologist. Approvals  Prerequisites(tick boxes where appropriate)			
The patient has obtained a respon period	se from treatment of at least 20,000 platelets per mic	crolitre above baseline during the initial approval	
	for a minimum of 8 weeks during the initial approval	period	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 47 **Form SA2272** June 2025

PATIENT NHI:	REFERRER Reg No:
First Names:	First Names:
Surname:	Surname:
DOB:	Address:
Address:	
	Fax Number:
mophilia A with a severe bleeding phenotype (endoge	enous factor VIII activity less than or equal to 2%)
at a dose of no greater than 3 mg/kg weekly for 4 we	eeks followed by the equivalent of 1.5 mg/kg
	First Names:  Surname:  DOB:  Address:

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 48 Form SA1955 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:	
Ticagrelor			
and		non-ST-elevation acute coronary syndrome	
Initial application — thrombosis prevention ne Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)			
Patient has had a neurological stenting procedure* in the last 60 days  Patient is about to have a neurological stenting procedure performed*			
Patient has demonstrated clopidogrel resistance using the P2Y12 (VerifyNow) assay or another appropriate platelet function assay and requires antiplatelet treatment with ticagrelor			
Clopidogrel resistance	e has been demonstrated by the occurrence of a new	cerebral ischemic event	
Clopidogrel resistance stent	tance has been demonstrated by the occurrence of transient ischemic attack symptoms referable to the		
Initial application — Percutaneous coronary in Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)			
Patient has undergone percutaned and Patient has had a stent deployed in and Patient is clopidogrel-allergic**	·		
Initial application — Stent thrombosis Applications from any relevant practitioner. Approv Prerequisites(tick box where appropriate)	vals valid without further renewal unless notified.		
Patient has experienced cardiac stent the	rombosis whilst on clopidogrel		

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 49 Form SA1955 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:	
Ticagrelor - continued			
Renewal — subsequent acute coronary syndro	me		
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	vals valid for 12 months.		
Patient has recently (within the last 60 days) been diagnosed with an ST-elevation or a non-ST-elevation acute coronary syndrome  and  Fibrinolytic therapy has not been given in the last 24 hours and is not planned			
Renewal — thrombosis prevention neurological stenting			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	vals valid for 12 months.		
Patient is continuing to benefit from	n treatment		
Treatment continues to be clinically	y appropriate		
Renewal — Percutaneous coronary interventio	n with stent deployment		
Current approval Number (if known):			
Applications from any relevant practitioner. Approx			
Prerequisites(tick boxes where appropriate)			
Patient has undergone percutanec	ous coronary intervention		
Patient has had a stent deployed in	n the previous 4 weeks		
Patient is clopidogrel-allergic**			

Note: indications marked with \* are unapproved indications.

Note: Note: \*\* Clopidogrel allergy is defined as a history of anaphylaxis, urticaria, generalised rash or asthma (in non-asthmatic patients) developing soon after clopidogrel is started and is considered unlikely to be caused by any other treatment.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 50 **Form SA2152** June 2025

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
Reg No:		First Names:	First Names:	
Name:		Surname:	Surname:	
Addre	SS:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Enox	aparin sodium			
Appli	l application — Pregnancy, Malignancy or cations from any relevant practitioner. Appropriates (tick boxes where appropriate)			
	Low molecular weight heparin trea	tment is required during a patients pregnancy		
	For the treatment of venous throm	boembolism where the patient has a malignancy		
	For the prevention of thrombus for	mation in the extra-corporeal circulation during haem	odialysis	
or For the prophylaxis and treatment				
		t of venous thromboembolism in Acute Coronary Syndrome surgical intervention		
	To be used in association with care	dioversion of atrial fibrillation		
Appli	I application — Short-term use during treactions from any relevant practitioner. Approxequisites(tick boxes where appropriate)	atment of COVID-19 with nirmatrelvir with ritonaviously vals valid for 2 weeks.	r	
	Patient is receiving an anticoagula	tion treatment that has drug/drug interactions with rite	onavir that increases risk of bleeding	
		for COVID-19 antivirals published on the Pharmac we	ebsite*	
		ID-19 have been considered and are not clinically sui	table options	
Curre Appli	Renewal — Pregnancy, Malignancy or Haemodialysis  Current approval Number (if known):			
	Low molecular weight heparin trea	tment is required during a patient's pregnancy		
	For the treatment of venous throm <b>or</b>	boembolism where the patient has a malignancy		
For the prevention of thrombus formation in the extra-corporeal circulation during haemodialysis		odialysis		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 51 **Form SA2152** 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:		
Enoxaparin sodium - continued				
Renewal — Venous thromboembolism other th	an in pregnancy or malignancy			
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 1 month.  Prerequisites(tick box where appropriate)				
Low molecular weight heparin treatment or prophylaxis is required for a second or subsequent event (surgery, ACS, cardioversion, or prior to oral anti-coagulation)				

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 52 **Form SA1259** 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:		
Filgrastim				
Initial application Applications only from a relevant specialist, vocationally registered general practitioner or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
Prevention of neutropenia in patien 20%*)				
Peripheral blood stem cell mobilisa	tion in patients undergoing haematological transplant	tation		
Peripheral blood stem cell mobilisa	Peripheral blood stem cell mobilisation or bone marrow donation from healthy donors for transplantation			
Treatment of severe chronic neutro	penia (ANC < 0.5 ×10 <sup>9</sup> /L)			
Treatment of drug-induced prolong	ed neutropenia (ANC < 0.5 ×10 <sup>9</sup> /L)			

Note: \*Febrile neutropenia risk greater than or equal to 20% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 53 **Form SA1912** 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:			
Pegfilgrastim					
Initial application Applications only from a relevant specialist, vocationally registered general practitioner or medical practitioner on the recommendation of a relevant specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)					
Used for prevention of neutropenia in pat 5%*)	ients undergoing high risk chemotherapy for cancer (	febrile neutropenia risk greater than or equal to			

Note: \*Febrile neutropenia risk greater than or equal to 5% after taking into account other risk factors as defined by the European Organisation for Research and Treatment of Cancer (EORTC) guidelines.

Cardiovascular System

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 55 Form SA2302 June 2025

APPLICAN <sup>-</sup>	T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name:		Surname:	Surname:
Address:		DOB:	Address:
		Address:	
Fax Number	r:		Fax Number:
Sacubitri	l with valsartan		
	Patient is in NYHA/WHO functional class II  Patient is in NYHA/WHO functional class III  Patient is in NYHA/WHO functional class IV		
	or	off ventricular ejection fraction (LVEF) of less than or expractical, and in the opinion of the treating practitione	
and  Patient is receiving concomitant optimal standard chronic heart failure treatments		and patient would belief from treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 56 Form SA1474 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:		
Midodrine				
Initial application Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)				
Patient has disabling orthostatic hypotension not due to drugs				
Renewal				
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)				
The treatment remains appropriate and the patient is benefiting from treatment				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 57 Form SA1327 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:	
Propranolol			
Initial application Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick boxes where appropriate)  For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only)  or  For the treatment of a child under 12 years with cardiac arrthymias or congenital cardiac abnormalities			
Renewal  Current approval Number (if known):			
For the treatment of a child under 12 years with an haemangioma causing functional impairment (not for cosmetic reasons only)  For the treatment of a child under 12 years with cardiac arrthymias or congenital cardiac abnormalities			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 58 Form SA1728 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:		
Eplerenone				
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
Patient has heart failure with ejection fraction less than 40%  and				
Patient is intolerant to optima	al dosing of spironolactone			
Patient has experienced a cl	sing of spironolactone			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 59 Form SA2166 June 2025

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name		Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Appli	Patient has a confirmed diagnosis  Patient has an estimated glomerula  Patient's disease is rapidly p	evant practitioner on the recommendation of a renal proof autosomal dominant polycystic kidney disease ar filtration rate (eGFR) of greater than or equal to 25 rogressing, with a decline in eGFR of greater than or rogressing, with an average decline in eGFR of greater	ml/min/1.73 m² at treatment initiation equal to 5 mL/min/1.73 m² within one-year
Renewal — autosomal dominant polycystic kidney disease  Current approval Number (if known):		physician. Approvals valid for 12 months.	
Patient has not developed end-stag		ge renal disease, defined as an eGFR of less than 15	5 mL/min/1.73 m <sup>2</sup>
	Patient has not undergone a kidner	y transplant	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 60 Form SA2093 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:	
Rosuvastatin			
Initial application — cardiovascular disease risk Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)			
Patient is considered to be a and Patient is Māori or any Pacif	at risk of cardiovascular disease		
and	of cardiovascular disease of at least 15% over 5 year		
and			
Initial application — established cardiovascula Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)			
Patient has proven coronary	r artery disease (CAD)		
Patient has proven periphera	al artery disease (PAD)		
Patient has experienced an	an ischaemic stroke		
and LDL cholesterol has not reduced to simvastatin	o less than 1.4 mmol/litre with treatment with the max	ximum tolerated dose of atorvastatin and/or	
Initial application — recurrent major cardiovas Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)			
hospitalisation for unstable angina		infarction, ischaemic stroke, coronary revascularisation	
LDL cholesterol has not reduced to simvastatin	o less than 1.0 mmol/litre with treatment with the ma.	ximum tolerated dose of atorvastatin and/or	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 61 Form SA1321 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:		
Hydralazine				
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
For the treatment of refractory hyp	ertension			
For the treatment of heart failure in combination with a nitrate, in patients who are intolerant or have not responded to ACE inhib and/or angiotensin receptor blockers				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 62 **Form SA2254** June 2025

APPLICANT (stamp or sticker acceptable)			sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name:	Name:			Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Number	·				Fax Number:
Bosentan	)				
Application cardiologist	s only t or rh	from eumat	PAH monotherapy a respiratory specialist, cardi tologist. Approvals valid for 6 es where appropriate)	iologist, rheumatologist or any relevant practitioner o 6 months.	n the recommendation of a respiratory specialist,
and [	_		t has pulmonary arterial hype in Group 1, 4 or 5 of the WH	ertension (PAH)*  HO (Venice 2003) clinical classifications	
and [ and	P	'AH is	in New York Heart Association	on/World Health Organization (NYHA/WHO) function	nal class II, III or IV
and A mean pulmonary arter and A pulmonary capillary of and Pulmonary vascular research and PAH has been do defined in the 20 or Patient has not earisk stratification or Patient has PAH  or Patient is a child with PAH see disorders including severe chor Patient has palliated single we Fontan circulation requiring the		A mean pulmonary arter  A pulmonary capillary v  Pulmonary vascular res  PAH has been de defined in the 200 or  Patient has not e risk stratification or  Patient has PAH  Patient is a child with PAH see disorders including severe che	other than idiopathic / heritable or drug-associated to	nHg 60 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as r link to these guidelines) † gonist treatment, according to a validated type diopathic, congenital or developmental lung	
		Bosentan is to be used as PA	NH monotherapy		
	and			d intolerable side effects on sildenafil	
	or			e contraindication to sildenafil	
		or	Patient is a child with ic	diopathic PAH or PAH secondary to congenital heart	disease

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 63 Form SA2254 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:		
Bosentan - continued				
cardiologist or rheumatologist. Approvals valid for Prerequisites (tick boxes where appropriate)  Patient has pulmonary arterial hy and  PAH is in Group 1, 4 or 5 of the V and				
PAH has been confirmed by right heart catheterisation				
and				
and	y wedge pressure (PCWP) less than or equal to 15 m	-		
Pulmonary vascular and	resistance greater than 2 Wood Units or greater than	160 International Units (dyn s cm <sup>-o</sup> )		
	demonstrated to be non-responsive in vasoreactivity 2022 ECS/ERS Guidelines for PAH (see note below for			
Patient has no risk stratification	t experienced an acceptable response to calcium anta on tool**	agonist treatment, according to a validated		
Patient has PA	H other than idiopathic / heritable or drug-associated	type		
	secondary to congenital heart disease or PAH due to chronic neonatal lung disease	idiopathic, congenital or developmental lung		
	ventricle congenital heart disease and elevated pulm the minimising of pulmonary/venous filling pressures			
and  Bosentan is to be used as part of	PAH dual therapy			
Patient has tried a PAH monotherapy (sildenafil) for at least three months and has experienced an inadequate therapeutic response to treatment according to a validated risk stratification tool**				
	Patient is presenting in NYHA/WHO functional class III or IV, and in the opinion of the treating clinician would likely benefit from initial dual therapy			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 64 Form SA2254 June 2025

APPLICANT (stamp or sticker acceptable) PATIENT NHI:	g No:		
Reg No: First Names: First Names:			
Name: Surname: Surname:			
Address: DOB:			
Address:			
Initial application — PAH triple therapy Applications only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommend cardiologist or rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient has pulmonary arterial hypertension (PAH)*  and  PAH is in Group 1, 4 or 5 of the WHO (Venice 2003) clinical classifications	ation of a respiratory specialist,		
and  PAH is in New York Heart Association/World Health Organization (NYHA/WHO) functional class II, III or I' and	v		
PAH has been confirmed by right heart catheterisation  and A mean pulmonary artery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repail and A pulmonary capillary wedge pressure (PCWP) less than or equal to 15 mmHg and Pulmonary vascular resistance greater than 2 Wood Units or greater than 160 International Uland PAH has been demonstrated to be non-responsive in vasoreactivity assessment using defined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelined in the 2022 ECS/ERS Guidelines for PAH (see note below for link to these guidelines to response to calcium antagonist treatment, a risk stratification tool**  Patient has PAH other than idiopathic / heritable or drug-associated type  or Patient is a child with PAH secondary to congenital heart disease or PAH due to idiopathic, congenital disorders including severe chronic neonatal lung disease	Jnits (dyn s cm <sup>-5</sup> )  iloprost or nitric oxide, as delines) †  according to a validated		
Patient has palliated single ventricle congenital heart disease and elevated pulmonary pressures of Fontan circulation requiring the minimising of pulmonary/venous filling pressures  and	a major complication of the		
Bosentan is to be used as part of PAH triple therapy			
Patient is on the lung transplant list  or  Patient is presenting in NYHA/WHO functional class IV  or			
Patient has tried PAH dual therapy for at least three months and has not experienced a treatment according to a validated risk stratification tool**	ın acceptable response to		
Patient does not have major life-threatening comorbidities and triple therapy is not bein scenario	g used in a palliative		

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 65 Form SA2254 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:	
Bosentan - continued			
Renewal			
Current approval Number (if known):			
Applications only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)			
Patient is continuing to derive benefit from bosentan treatment according to a validated PAH risk stratification tool**			

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary

hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 66 Form SA2486 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:Ambrisentan		Fax Number:	
Initial application — PAH monotherapy Applications only from a respiratory specialist, card cardiologist or rheumatologist. Approvals valid for Prerequisites(tick boxes where appropriate)	liologist, rheumatologist or any relevant practitioner o 6 months.	n the recommendation of a respiratory specialist,	
and	ertension (PAH)  HO (Venice 2003) clinical classifications  ion/World Health Organization (NYHA/WHO) function	nal class II, III or IV	
and A mean pulmonary art and A pulmonary capillary and Pulmonary vascular re and PAH has been d defined in the 20 or Patient has not e risk stratification Patient has PAH	other than idiopathic / heritable or drug-associated to	nHg 60 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as ow for link to these guidelines) † gonist treatment, according to a validated ype	
Fontan circulation requiring t	entricle congenital heart disease and elevated pulmo he minimising of pulmonary/venous filling pressures	nary pressures or a major complication of the	
Ambrisentan is to be used as			
Patient has experience	ed intolerable side effects with both sildenafil and bos	entan	
	e contraindication to sildenafil and an absolute or rela ned oral contraceptive or liver disease)	ative contraindication to bosentan (e.g. due to	
Patient is a child with in	diopathic PAH or PAH secondary to congenital heart	disease	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 67 Form SA2486 June 2025

APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Address:				DOB:	Address:
				Address:	
Fax Num	ber:				Fax Number:
Ambris	entan	- cont	tinued		
Applicat cardiolo Prerequ ai	ions only gist or rhe isites (tions)  Find  Find	from eumat ck box Patient	tologist. Approvals valid for es where appropriate)  has pulmonary arterial hyp in Group 1, 4 or 5 of the W in New York Heart Associa  PAH has been confirm  A mean pulmonary ar		nal class II, III or IV peri Fontan repair)
		and	or PAH has been of defined in the 2 Patient has not risk stratification	demonstrated to be non-responsive in vasoreactivity a 022 ECS/ERS Guidelines for PAH 2022 (see note be experienced an acceptable response to calcium antain tool**  H other than idiopathic / heritable or drug-associated t	assessment using iloprost or nitric oxide, as low for link to these guidelines) † gonist treatment, according to a validated
	or   or	c	disorders including chronic relations and a single value of the si	econdary to congenital heart disease or PAH due to ineonatal lung disease  ventricle congenital heart disease and elevated pulmothe minimising of pulmonary/venous filling pressures	
aı	Ambrisentan is to be used as PAH dual therapy  and  Patient has tried bosentan (either as PAH monotherapy, or PAH dual therapy with sildenafil) for at least three months and has not experienced an acceptable response to treatment according to a validated risk stratification tool**				
		or	Patient has an absolu or liver disease)  Patient is presenting i	ed intolerable side effects on bosentan  te or relative contraindication to bosentan (e.g. due to  n NYHA/WHO functional class III or IV, and would be  nd has an absolute or relative contraindication to bos  ntraceptive)	nefit from initial dual therapy in the opinion of

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 68 **Form SA2486** June 2025

APPLICANT (stamp or sticker acceptable)		np or sticker acceptable	e) PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Address:			DOB:	Address:	
			Address:		
ax Numbe	er:			Fax Number:	
Ambrise	ntan -	continued			
Application cardiologis	ns only to the sites (tick	eumatologist. Approval k boxes where appropr	ialist, cardiologist, rheumatologist or any reles valid for 6 months. iate)	evant practitioner on the recommendation of a respiratory specialist,	
and		atient has pulmonary a	rterial hypertension (PAH)		
and		AH is in Group 1, 4 or 5	5 of the WHO (Venice 2003) clinical classifica	tions	
and	D PA	AH is in New York Hea	rt Association/World Health Organization (NY	(HA/WHO) functional class II, III or IV	
and		DALL been be			
		and	en confirmed by right heart catheterisation	_	
		and		rtery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair) r wedge pressure (PCWP) less than or equal to 15 mmHg	
		A pulmonary	capillary wedge pressure (PCWP) less than		
		Pulmonary v	rascular resistance greater than 2 Wood Unit	s or greater than 160 International Units (dyn s cm <sup>-5</sup> )	
	PAH has been demonstrated to be non-responsive in vasoreactivity assessment using iloprost or nitric or defined in the 2022 ECS/ERS Guidelines for PAH 2022 (see note below for link to these guidelines) †  Patient has not experienced an acceptable response to calcium antagonist treatment, according to a valid			2022 (see note below for link to these guidelines) †	
		or risk st	ratification tool** nt has PAH other than idiopathic / heritable or		
	or		·		
	or _		rith PAH secondary to congenital heart diseas g chronic neonatal lung disease	se or PAH due to idiopathic, congenital or developmental lung	
and			ed single ventricle congenital heart disease a requiring the minimising of pulmonary/venou	nd elevated pulmonary pressures or a major complication of the s filling pressures	
anu	and	Ambrisentan is to	be used as PAH triple therapy		
		Patient is or	the lung transplant list		
		Patier and	nt is presenting in NYHA/WHO functional clas	ss IV	
		Patier contra	nt has an absolute or relative contraindication aceptive or liver disease)	to bosentan (e.g. due to current use of a combined oral	
			nt has tried PAH dual therapy for at least three ding to a validated risk stratification tool**	e months and remains in an unacceptable risk category	
				bidities and triple therapy is not being used in a palliative	

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 69 Form SA2486 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:	
Ambrisentan - continued			
Renewal			
Current approval Number (if known):			
Applications only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years.			
Prerequisites(tick box where appropriate)			
The patient is continuing to derive benefit from ambrisentan treatment according to a validated PAH risk stratification tool**			

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary

hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 70 **Form SA2255** 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:
Sildenafil (Vedafil)		
Initial application — Raynaud's Phenomenon* Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	als valid without further renewal unless notified.	
and Patient is following lifestyle manag sympathomimetic drugs)  and	on* ia (defined as severe pain requiring hospital admission ement (avoidance of cold exposure, sufficient protect m channel blockers and nitrates (or these are contrain	ion, smoking cessation support, avoidance of
and	ertension (PAH)*  HO (Venice 2003) clinical classifications  tion/World Health Organization (NYHA/WHO) function	nal class II, III or IV
and A pulmonary capillary	ight heart catheterisation tery pressure (PAPm) of greater than 20 mmHg wedge pressure (PCWP) that is less than or equal to esistance (PVR) of at least 2 Wood Units or greater th	_
or Guidelines for P  Patient has not risk stratification	consive in vasoreactivity assessment using iloprost or AH (see note below for link to these guidelines) † experienced an acceptable response to calcium anta tool**  If other than idiopathic / heritable or drug-associated to	gonist treatment, according to a validated
or disorders including severe c	econdary to congenital heart disease or PAH due to i hronic neonatal lung disease rentricle congenital heart disease and elevated pulmo the minimising of pulmonary/venous filling pressures	

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 71 Form SA2255 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:		
Sildenafil (Vedafil) - continued				
Initial application — erectile dysfunction due to spinal cord injury Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)				
Patient has a documented history of traumatic or non-traumatic spinal cord injury  and Patient has a documented history of traumatic or non-traumatic spinal cord injury  Patient has erectile dysfunction secondary to spinal cord injury requiring pharmacological treatment				
Demonds are stills directive steep due to existed and injury.				
Renewal — erectile dysfunction due to spinal cord injury  Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)				
The treatment remains appropriate and the patient is benefiting from treatment				

Note: Note: Indications marked with \* are Unapproved Indications.

† The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 72 Form SA2257 June 2025

APPLICANT (stamp or sticker acceptable)		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:	
loprost					
Applications cardiologist	s only fro or rheun tes(tick b Patie PAH PAH ar ar	natologist. Approvals valid for oxes where appropriate)  ent has pulmonary arterial hypris in Group 1, 4 or 5 of the William is in New York Heart Associa  PAH has been confirm A mean pulmonary arterial hypris in New York Heart Associa  A mean pulmonary arterial hypris in New York Heart Associa  A mean pulmonary arterial hypris in New York Heart Associa  PAH has been confirm A pulmonary vascular arterial A pulmonary vascular arterial PAH has been defined in the 2 or Patient has not risk stratification	nertension (PAH)  HO (Venice 2003) clinical classifications  tion/World Health Organization (NYHA/WHO) function  med by right heart catheterisation  tery pressure (PAPm) greater than 20 mmHg (unless  wedge pressure (PCWP) less than or equal to 15 mm  resistance greater than 2 Wood Units or greater than  demonstrated to be non-responsive in vasoreactivity at 1022 ECS/ERS Guidelines for PAH (see note below for 1022 experienced an acceptable response to calcium antal	peri Fontan repair) mHg n 160 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as r link to these guidelines) † gonist treatment, according to a validated	
and	or	Patient is a child with PAH s disorders including chronic in Patient has palliated single singles.	econdary to congenital heart disease or PAH due to i	diopathic, congenital or developmental lung	
	and	both bosentan and an	ed intolerable side effects on sildenafil and both the fo		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 73 Form SA2257 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:
lloprost - continued		
PAH has been confirmand  A pulmonary vascular and  A pulmonary vascular and  A pulmonary vascular and  A pulmonary vascular and  PAH has been defined in the 2 or	pertension (PAH)  WHO (Venice 2003) clinical classifications  ation/World Health Organization (NYHA/WHO) function  med by right heart catheterisation  artery pressure (PAPm) greater than 20 mmHg (unless by wedge pressure (PCWP) less than or equal to 15 mm  ar resistance greater than 2 Wood Units or greater than demonstrated to be non-responsive in vasoreactivity at 2022 ECS/ERS Guidelines for PAH (see note below for the experienced an acceptable response to calcium antal	peri Fontan repair) mHg n 160 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as ir link to these guidelines) †
or  Patient is a child with PAH adisorders including chronic  Patient has palliated single Fontan circulation requiring  and  Iloprost is to be used as PA  and	ventricle congenital heart disease and elevated pulmonary the minimising of pulmonary/venous filling pressures  AH dual therapy with either sildenafil or an endothelin r	diopathic, congenital or developmental lung onary pressures or a major complication of the eceptor antagonist
or Patient has an absolute receptor antagonist	ute contraindication to or has experienced intolerable sute or relative contraindication to or experienced intole  AH monotherapy for at least three months and remains attification tool**	rable side effects with a funded endothelin
Patient is presenting initial dual therapy	in NYHA/WHO functional class III or IV, and in the opi	nion of the treating clinician would benefit from

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
rardiologist or rheumatologist. Approvals valid for Prerequisites (tick boxes where appropriate)  Patient has pulmonary arterial hypand PAH is in Group 1, 4 or 5 of the Wand PAH is in New York Heart Associa and PAH has been confirmand A mean pulmonary ar and A pulmonary capillary and PAH has been confirmand A pulmonary vascular and PAH has been confirmand PAH has	hertension (PAH)  HO (Venice 2003) clinical classifications  tion/World Health Organization (NYHA/WHO) function  med by right heart catheterisation  tery pressure (PAPm) greater than 20 mmHg (unless  wedge pressure (PCWP) less than or equal to 15 mm  resistance greater than 2 Wood Units or greater than  demonstrated to be non-responsive in vasoreactivity at 1022 ECS/ERS Guidelines for PAH (see note below for 1001)  experienced an acceptable response to calcium antain tool**  H other than idiopathic / heritable or drug-associated to 1001  econdary to congenital heart disease or PAH due to interest the 1001 of 1001  eventricle congenital heart disease and elevated pulmon the minimising of pulmonary/venous filling pressures  H triple therapy	peri Fontan repair) mHg n 160 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as or link to these guidelines) † agonist treatment, according to a validated type
or Patient has tried	n NYHA/WHO functional class IV	not experienced an acceptable response to
and	rding to a validated risk stratification tool**  t have major life-threatening comorbidities and triple	therapy is not being used in a palliative

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 75 Form SA2257 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:	
lloprost - continued			
Renewal			
Current approval Number (if known):			
Applications only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)			
Patient is continuing to derive benefit from iloprost treatment according to a validated PAH risk stratification tool**			

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary

hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICAN	<b>T</b> (stam	p or	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No: F			First Names:	First Names:	
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Numbe					Fax Number:
Epoprost	tenol				
Application cardiologis	ns only t t or rhe	from a	PAH dual therapy a respiratory specialist, care ologist. Approvals valid for es where appropriate)	diologist, rheumatologist or any relevant practitioner of 6 months.	on the recommendation of a respiratory specialist,
and		AH is		ertension (PAH)  HO (Venice 2003) clinical classifications  tion/World Health Organization (NYHA/WHO) functio	nal class III or IV
and	and			ned by right heart catheterisation	THAT CLASS III OF TV
			A mean pulmonary ar	rtery pressure (PAPm) greater than 20 mmHg (unless peri Fontan repair)	
		A pulmonary capillary	wedge pressure (PCWP) less than or equal to 15 mi	mHg	
		and and	A pulmonary vascular	resistance greater than 2 Wood Units or greater than	n 160 International Units (dyn s cm <sup>-5</sup> )
				demonstrated to be non-responsive in vasoreactivity of 22 ECS/ERS Guidelines for PAH (see note below for	
			Patient has not risk stratification	experienced an acceptable response to calcium antantolors	gonist treatment, according to a validated
			Patient has PAF	d other than idiopathic / heritable or drug-associated	type
	or [	d F	lisorders including chronic r Patient has palliated single v	econdary to congenital heart disease or PAH due to neonatal lung disease ventricle congenital heart disease and elevated pulme the minimising of pulmonary/venous filling pressures	onary pressures or a major complication of the
and		_			
	and_	_  E	poprostenol is to be used a	as part of PAH dual therapy with either sildenafil or ar	n endothelin receptor antagonist
	Patient is presenting in NYH		Patient is presenting in NYH	A/WHO functional class IV	
			Patient has tried a PAH mon alidated risk stratification to	otherapy for at least three months and remains in an ol	unacceptable risk category according to a

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Numbe	r:				Fax Number:
Epoprosi	tenol	- con	tinued		
Application cardiologis	ns only st or rhe ites(tic	from a eumat k boxe atient AH is	ologist. Approvals valid for es where appropriate) has pulmonary arterial hypin Group 1, 4 or 5 of the W		
and	or [	d	A mean pulmonary ar  A pulmonary capillary  A pulmonary vascular  PAH has been of defined in the 2  Or  Patient has not risk stratification  Patient has PAH  Patient is a child with PAH solisorders including chronic in patient has palliated single in the patient has pat	d other than idiopathic / heritable or drug-associated the drug-as	mHg 160 International Units (dyn s cm <sup>-5</sup> ) assessment using iloprost or nitric oxide, as r link to these guidelines) † gonist treatment, according to a validated type diopathic, congenital or developmental lung
and	and	or or	Patient has tried treatment accordand		
			Sociiano		

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Epoprostenol - continued			
Renewal			
Current approval Number (if known):			
Applications only from a respiratory specialist, cardiologist, rheumatologist or any relevant practitioner on the recommendation of a respiratory specialist, cardiologist or rheumatologist. Approvals valid for 2 years.			
Prerequisites(tick box where appropriate)			
Patient is continuing to derive benefit from	n epoprostenol treatment according to a validated PA	H risk stratification tool**	

Note: † The European Respiratory Journal Guidelines can be found here: 2022 ECS/ERS Guidelines for the diagnosis and treatment of pulmonary

hypertension PAH

\*\* the requirement to use a validated risk stratification tool to determine insufficient response applies to adults. Determining insufficient response in children does not require use of a validated PAH risk stratification tool, where currently no such validated tools exist for PAH risk stratification in children.

#### **Dermatologicals**

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 80 Form SA2449 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:
Isotretinoin		
and  Applicant has an up to date knowle and  Patient is of child bearing por patient has been counselled not become pregnant during or  Patient is not of child bearing or	ed dermatologist, paediatrician, vocationally registere ctice edge of the safety issues around isotretinoin and is contential and the possibility of pregnancy has been exceed and understands the risk of teratogenicity if isotreting treatment and for a period of one month after the co	ompetent to prescribe isotretinoin luded prior to commencement of treatment and prior is used during pregnancy and that they must impletion of treatment
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick boxes where appropriate)		
has been counselled and understa pregnant during treatment and for  or  Patient is not of child bearing poter  or	and the possibility of pregnancy has been excluded unds the risk of teratogenicity if isotretinoin is used dual period of one month after the completion of treatmential ed not appropriate to exclude pregnancy or start cont	ring pregnancy and that they must not become ent

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 81 Form SA2294 June 2025

APPL	ICAN	T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg I	No:		First Names:	First Names:
Name	e:		Surname:	Surname:
Addre	ess:		DOB:	Address:
			Address:	
Fax N	lumbe	r:		Fax Number:
lverr	nect	in		
Appl	ication		nyperinfestation (Crusted/ Norwegian scabies)	
		and The person is unable to	diagnosis of scabies or is a close contact of a scabie to complete topical therapy th topical therapy has been tried and not cleared the	
Appl	ication	lication — Other parasitic infections as from any relevant practitioner. Approxites(tick boxes where appropriate)	vals valid for 1 month.	
		Filariasis		
	or	Cutaneous larva migrans (creepino	g eruption)	
	or	Strongyloidiasis		
Ren	ewal -	- Scabies		
		proval Number (if known):		
		ns from any relevant practitioner. Approvites (tick boxes where appropriate)	als valid for 1 month.	
	or	The person has a severe scables h	nyperinfestation (Crusted/ Norwegian scables)	
		The person has a confirmed	diagnosis of scabies or is a close contact of a scabie	es case
			to complete topical therapy	
		Previous treatment wit	th topical therapy has been tried and not cleared the	infestation
l	1			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 82 **Form SA2294** 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:
Ivermectin - continued		
Renewal — Other parasitic infections		
Current approval Number (if known):		
Applications from any relevant practitioner. Appro-	als valid for 1 month.	
Prerequisites(tick boxes where appropriate)		
Filariasis		
Cutaneous larva migrans (creepin	g eruption)	
or Strongyloidiasis		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 83 Form SA2074 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:
Tacrolimus Ointment		
Initial application Applications only from a dermatologist, paediatrici valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)	an or any relevant practitioner on the recommendatio	n of a dermatologist, paediatrician, . Approvals
Patient has atopic dermatitis on th	e face	
	wing contraindications to topical corticosteroids: per allergy to topical corticosteroids	iorificial dermatitis, rosacea, documented

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 84 Form SA2024 June 2025

F: AN
First Names:
Surname:
Address:
Fax Number:
red general practitioner, or nurse practitioner working in a retin and is competent to prescribe acitretin  by has been excluded prior to commencement of treatment and inicity if acitretin is used during pregnancy and that they must ears after the completion of treatment
been excluded prior to commencement of treatment and patient in is used during pregnancy and that they must not become pletion of treatment
·

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 85 Form SA1970 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:			
Pimecrolimus	Pimecrolimus				
Initial application Applications only from a dermatologist, paediatrician, ophthalmologist or any relevant practitioner on the recommendation of a dermatologist, paediatrician or ophthalmologist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)					
Patient has atopic dermatitis on the	e eyelid				
Patient has at least one of the follo	wing contraindications to topical corticosteroids: peri ergy to topical corticosteroids, cataracts, glaucoma, o	· · · · · · · · · · · · · · · · · · ·			

**Genito-Urinary System** 

#### APPLICATION FOR ALTERNATE SUBSIDY BY SPECIAL AUTHORITY

Page 87 **Form SA0500** 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:	
Combined oral contraceptives; Proges	togen-only contraceptives (Circle one)		
Initial application Applications from any medical practitioner. Approve Prerequisites(tick boxes where appropriate)  Patient is on a Social Welfare or Patient has an income no great and Has tried at least one of the fully further appropriate.	e benefit		
Renewal  Current approval Number (if known):			

Note: The approval numbers of Special Authorities approved after 1 November 1999 are interchangeable between Mercilon and Marvelon. The additional subsidy will fund Mercilon and Marvelon up to the manufacturer's price for each of these products as identified on the Schedule at 1 November 1999.

Special Authorities approved before 1 November 1999 remain valid until the expiry date and can be renewed providing that women are still either:

- on a Social Welfare benefit; or
- have an income no greater than the benefit.

The approval numbers of Special Authorities approved before 1 November 1999 are interchangeable for products within the combined oral contraceptives and progestogen-only contraceptives groups, except Loette and Microgynon 20 ED

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 88 Form SA0928 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:		
Finasteride				
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
Patient has symptomatic benign p	rostatic hyperplasia			
The patient is intolerant of n	on-selective alpha blockers or these are contraindica	ted		
	ly controlled with non-selective alpha blockers			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 89 Form SA1032 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:		
Tamsulosin				
Initial application Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	als valid without further renewal unless notified.			
Patient has symptomatic benign prostatic hyperplasia				
The patient is intolerant of non-sel	ective alpha blockers or these are contraindicated			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 90 Form SA1083 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:	
Potassium Citrate			
Initial application Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has recurrent calcium oxalate urolithiasis and The patient has had more than two renal calculi in the two years prior to the application			
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)			
The treatment remains appropriate and t	he patient is benefitting from the treatment		

**Hormone Preparations - Systemic Excluding Contraceptive Hormones** 

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 92 **Form SA2170** June 2025

APPLICANT (stamp or sticker acceptable) PATIENT NHI:		PATIENT NHI:	REFERRER Reg No:	
Reg N	lo:		First Names:	First Names:
Name	:		Surname:	Surname:
Addre	ss:		DOB:	Address:
			Address:	
Fax N	umbe	r:		Fax Number:
Cina	calc	et		
Appli	cation	lication — parathyroid carcinoma or as only from a nephrologist or endocrino ites(tick boxes where appropriate)		
		and  The patient has persistent h	osed with a parathyroid carcinoma (see Note)  ypercalcaemia (serum calcium greater than or equal thiosulfate (where appropriate) and bisphosphonates	
The patient has been diagnosed with calciphylaxis (calcific uraemic arteriolopathy)  and  The patient has symptomatic (e.g. painful skin ulcers) hypercalcaemia (serum calcium greater than or equal to 3 mmol/L)  and  The patient's condition has not responded to previous first-line treatments including bisphosphonates and sodium thiosulfations.			alcium greater than or equal to 3 mmol/L)	
Curre Appli Prere	Renewal — parathyroid carcinoma or calciphylaxis  Current approval Number (if known):			s notified.
Note: This does not include parathyroid adenomas unless these have become malignant.				
Initial application — primary hyperparathyroidism Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
	and	Patient has primary hyperparathyr		
		or	of more than 3 mmol/L with or without symptoms of more than 2.85 mmol/L with symptoms	
	and and	Surgery is not feasible or has faile Patient has other comorbidities, se	d	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 93 Form SA2170 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	:	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Cina	calcet - continued		
Initial application — secondary or tertiary hyperparathyroidism Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient has tertiary hyperparathyroidism and markedly elevated parathyroid hormone (PTH) with hypercalcaemia  Patient has symptomatic secondary hyperparathyroidism and elevated PTH  and Patient is on renal replacement therapy  and Residual parathyroid tissue has not been localised despite repeat unsuccessful parathyroid explorations  or Parathyroid tissue is surgically inaccessible  or Parathyroid surgery is not feasible			
Renewal — secondary or tertiary hyperparathyroidism  Current approval Number (if known):			
	hormone (PTH) level to support on	plant, and following a treatment free interval of at lea going cessation of treatment has not been reached ney transplant and trial of withdrawal of cinacalcet is	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 94 Form SA1199 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:		
Propylthiouracil				
Initial application Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	als valid for 2 years.			
The patient has hyperthyroidism				
The patient is intolerant of carbima	zole or carbimazole is contraindicated			
Renewal				
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)				
The treatment remains appropriate and the patient is benefitting from the treatment				

#### SA2032 - Somatropin

Prader-Willi syndrome - Initial application	99
Prader-Willi syndrome - Renewal	
Turner syndrome - Initial application	
Turner syndrome - Renewal	97
Adults and adolescents - Initial application	100
Adults and adolescents - Renewal	101
Growth hormone deficiency in children - Initial application	96
Growth hormone deficiency in children - Renewal	
Short stature due to chronic renal insufficiency - Initial application	
Short stature due to chronic renal insufficiency - Renewal	
Short stature without growth hormone deficiency - Initial application	97
Short stature without growth hormone deficiency - Renewal	97

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 96 Form SA2032 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:
Somatropin		
Initial application — growth hormone deficiency Applications only from a paediatric endocrinologist Prerequisites(tick boxes where appropriate)		
cardiomyopathy, hepatic dysfunction	symptomatic hypoglycaemia, or with other significantly and diagnosed with GH < 5 mcg/l on at least two hed hypoglycaemia (whole blood glucose < 2 mmol.	random blood samples in the first 2 weeks of
Height velocity < 25th percenstandards of Tanner and Davi	tile for age adjusted for bone age/pubertal status if a es (1985)	appropriate over 6 or 12 months using the
and	ars (female patients) or < 16 years (male patients)	
are 5 years or older, GH testir	of < 5.0 mcg per litre in response to two different groing with sex steroid priming is required	wth hormone stimulation tests. In children who
	n treated for a malignancy, they should be disease free for at least one year based upon follow-up ogical imaging appropriate for the malignancy, unless there are strong medical reasons why this is either	
and	uitary gland has been obtained	
Renewal — growth hormone deficiency in children	en	
Current approval Number (if known):		
Applications only from a paediatric endocrinologist of <b>Prerequisites</b> (tick boxes where appropriate)	or endocrinologist. Approvals valid for 12 months.	
A current bone age is 14 years or un	nder (female patients) or 16 years or under (male pa	atients)
Height velocity is greater than or eq	ual to 25th percentile for age (adjusted for bone age ver six months using the standards of Tanner and D	
	ual to 2.0 cm per year, as calculated over 6 months	
	atients specialist considers is likely to be attributable	e to growth hormone treatment has occurred
No malignancy has developed since	e starting growth hormone	
Initial application — Turner syndrome Applications only from a paediatric endocrinologist Prerequisites(tick boxes where appropriate)	or endocrinologist. Approvals valid for 9 months.	
The patient has a post-natal genoty	pe confirming Turner Syndrome	
	over 6-12 months using the standards of Tanner and	I Davies (1985)
A current bone age is < 14 years		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	lo:	First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	SS:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Som	atropin - continued			
Rene	ewal — Turner syndrome			
Curre	ent approval Number (if known):			
	cations only from a paediatric endocrinologist equisites(tick boxes where appropriate)	or endocrinologist. Approvals valid for 12 months.		
	Height velocity is greater than or ended Ranke's Turner Syndrome growth wand	qual to 50th percentile for age (while on growth horm velocity charts)	one calculated over 6 to 12 months using the	
	Height velocity is greater than or e	qual to 2 cm per year, calculated over six months		
	A current bone age is 14 years or u	under		
	No serious adverse effect that the	specialist considers is likely to be attributable to grow	rth hormone treatment has occurred	
	and  No malignancy has developed since	ce starting growth hormone		
App	Il application — short stature without grow ications only from a paediatric endocrinologis equisites(tick boxes where appropriate)	rth hormone deficiency t or endocrinologist. Approvals valid for 9 months.		
	delay	standard deviations below the mean for age or for b	one age if there is marked growth acceleration or	
	the standards of Tanner and Davie	for age (adjusted for bone age/pubertal status if app s(1985)	ropriate), as calculated over 6 to 12 months using	
	A current bone age is < 14 years o	r under (female patients) or < 16 years (male patient	s)	
	The patient does not have severe of medications known to impair heigh	chronic disease (including malignancy or recognized it velocity	severe skeletal dysplasia) and is not receiving	
Renewal — short stature without growth hormone deficiency				
	-	•		
Current approval Number (if known):				
	equisites(tick boxes where appropriate)	о опасотно од от трротато нападот д		
	12 months using the standards of	qual to 50th percentile (adjusted for bone age/pubert Tanner and Davies (1985)	al status if appropriate) as calculated over 6 to	
	and	qual to 2 cm per year as calculated over six months		
		qual to 2 on por your as salealated ever six months		
	and	under (female patients) or 16 years or under (male patients)	atients)	
	A current bone age is 14 years or the and			

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 98 Form SA2032 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	:	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Som	atropin - continued		
Appl endo	crinologist. Approvals valid for 9 months. equisites(tick boxes where appropriate)  The patient's height is more than 2 and Height velocity is < 25th percentile standards of Tanner and Davies (1 and A current bone age is to 14 years of the patient is metabolically stable, and The patient is under the supervision and The patient has a GFR less creatinine (umol/l)) × 40 = color	t, endocrinologist or renal physician on the recommendation of the	ale patients) sence of any other severe chronic disease the Schwartz method (Height(cm)/plasma may not be receiving dialysis
		,	
Rene	ewal — short stature due to chronic renal i	nsufficiency	
Appli endo	ent approval Number (if known): cations only from a paediatric endocrinologist crinologist. Approvals valid for 12 months. equisites(tick boxes where appropriate)	, endocrinologist or renal physician on the recommer	ndation of a paediatric endocrinologist or
	Height velocity is greater than or ea 12 months using the standards of and	qual to 50th percentile (adjusted for bone age/pubert Tanner and Davies (1985)	al status if appropriate) as calculated over 6 to
	Height velocity is greater than or e	qual to 2 cm per year as calculated over six months	
		under (female patients) or 16 years or under (male pa	atients)
	No serious adverse effect that the	patients specialist considers is likely to be attributable	e to growth hormone has occurred
	No malignancy has developed after	r growth hormone therapy was commenced	
		gnificant biochemical or metabolic deterioration confi	rmed by diagnostic results
		transplantation since starting growth hormone treatm	nent
	If the patient requires transplantation made after transplantation based of	on, growth hormone prescription should cease before on the above criteria	e transplantation and a new application should be

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Somatropin - continued		
Initial application — Prader-Willi syndrome Applications only from a paediatric endocrinologis Prerequisites(tick boxes where appropriate)  The patient has a diagnosis of Pradand The patient is aged six months or	der-Willi syndrome that has been confirmed by genet	ic testing or clinical scoring criteria
and A current bone age is < 14 years (f	remale patients) or < 16 years (male patients)	
	y have been performed and there is no obstructive slop, it has been adequately treated under the care of a p	
	o years or older of type II diabetes or uncontrolled obesity defined by deviations in the preceding 12 months	BMI that has increased by greater than or
	six months and two years and a thorough upper airvement and at six to 12 weeks following treatment initial	
Ponowal Prador Willi cyndromo		
Renewal — Prader-Willi syndrome		
Current approval Number (if known):  Applications only from a paediatric endocrinologist  Prerequisites(tick boxes where appropriate)		
Height velocity is greater than or educated the standards of and	qual to 50th percentile (adjusted for bone age/pubert Tanner and Davies (1985)	al status if appropriate) as calculated over 6 to
Height velocity is greater than or ea	qual to 2 cm per year as calculated over six months	
, <u> </u>	under (female patients) or 16 years or under (male pa	atients)
	patient's specialist considers is likely to be attributable	e to growth hormone treatment has occurred
	r growth hormone therapy was commenced	
The patient has not developed type 0.5 standard deviations in the prec	e II diabetes or uncontrolled obesity as defined by BN eding 12 months	II that has increased by greater than or equal to

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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		Julie 2023
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:
Somatropin - continued		
treatment of a pituitary tumour)  and The patient has undergone approp and The patient has severe growth horr and The patient's serum IGF-I is more t and The patient has poor quality of life, growth hormone deficiency (QoL-Ar  Note: For the purposes of adults and adolescents, equal to 3 mcg per litre during an adequately perfo Patients with one or more additional anterior pituita	n that is known to cause growth hormone deficiency riate treatment of other hormonal deficiencies and particles and particles are deficiency (see notes)  than 1 standard deviation below the mean for age an as defined by a score of 16 or more using the disea	sychological illnesses  d sex se-specific quality of life questionnaire for adult eak serum growth hormone level of less than or tion test. itary lesion only require one test. Patients with
an additional test is required, an arginine provocation test can be used with a peak serum growth hormone level of less than or equal to 0.4 mcg per litre. The dose of somatropin should be started at 0.2 mg daily and be titrated by 0.1 mg monthly until the serum IGF-I is within 1 standard deviation of the mean normal value for age and sex; and		
	for male patients, or 1 mg per day for female patients rism, patients must be monitored for any required adj	

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 101 Form SA2032 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:
Somatropin - continued		
Renewal — adults and adolescents		
Current approval Number (if known):	gist or endocrinologist. Approvals valid for 12 months.	
and  There has been an improgrowth Hormone Deficie and  Serum IGF-I levels have and  The dose of somatropin I  or  The patient has been treated and  Serum IGF-I levels have obvious external factors) and  The dose of somatropin I  or  The patient has had a Sprenewal criteria under thi and  The patient has had a Sprenewal criteria under thi and  The patient has undergote and	ated with somatropin for < 12 months  overment in Quality of Life defined as a reduction of at leading in Adults (QoL-AGHDA®) score from baseline  been increased within ±1SD of the mean of the normal mass not exceeded 0.7 mg per day for male patients, or a reduction in Quality of Life defined as a 6 point or a rethan due to obvious external factors such as external accontinued to be maintained within ±1SD of the mean of th	range for age and sex  1 mg per day for female patients  greater increase from their lowest QoL-AGHDA® stressors)  f the normal range for age and sex (other than for mg per day for female patients  eficiency in children and no longer meets the
and	I is more than 1 standard deviation below the mean for ality of life, as defined by a score of 16 or more using the ficiency (QoL-AGHDA®)	
equal to 3 mcg per litre during an adequately per Patients with one or more additional anterior pit isolated growth hormone deficiency require two an additional test is required, an arginine provous The dose of somatropin should be started at 0. mean normal value for age and sex; and Dose of somatropin not to exceed 0.7 mg per definition.	nts, severe growth hormone deficiency is defined as a performed insulin tolerance test (ITT) or glucagon stimulativitary hormone deficiencies and a known structural pite growth hormone stimulation tests, of which, one shoul cation test can be used with a peak serum growth horm 2 mg daily and be titrated by 0.1 mg monthly until the stay for male patients, or 1 mg per day for female patient uitarism, patients must be monitored for any required acceptable.	ation test.  uitary lesion only require one test. Patients with d be ITT unless otherwise contraindicated. Where none level of less than or equal to 0.4 mcg per litre. serum IGF-I is within 1 standard deviation of the ts.

# APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Page 102 Form **SA2070** June 2025

		REFERRER Reg No:
Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Cabergoline		
Initial application Applications from any relevant practitioner. Approva Prerequisites(tick boxes where appropriate)  Hyperprolactinemia or Acromegaly* or Inhibition of lactation	lls valid without further renewal unless notified.	
Renewal — for patients who have previously been funded under Special Authority form SA1031  Current approval Number (if known):		

Note: Indication marked with \* is an unapproved indication.

Infections - Agents for Systemic Use

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 104 Form SA1318 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:
Albendazole		
Initial application Applications only from an infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)		
The patient has hydatids		
Renewal		
Current approval Number (if known):		
Applications only from an infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)		
The treatment remains appropriate and the	ne patient is benefitting from the treatment	

# APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Page 105 Form SA1683 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:
Initial application — bronchiolitis obliterans sy Applications only from a relevant specialist. Appro Prerequisites(tick boxes where appropriate)	ndrome, cystic fibrosis and atypical Mycobacterivals valid without further renewal unless notified.	um infections
Patient has received a lung transpl syndrome*	ant, stem cell transplant, or bone marrow transplant	and requires treatment for bronchiolitis obliterans
	ant and requires prophylaxis for bronchiolitis oblitera	ns syndrome*
Patient has cystic fibrosis and has chronic infection with Pseudomonas aeruginosa or Pseudomonas-related gram negative organisms*  or		
Patient has an atypical Mycobacter	rium infection	
Note: Indications marked with * are unapproved in	dications.	
Initial application — non-cystic fibrosis bronch Applications only from a respiratory specialist or particular properties (tick boxes where appropriate)		
For prophylaxis of exacerbations o	f non-cystic fibrosis bronchiectasis*	
Patient is aged 18 and under		
	cacerbations of their bronchiectasis, within a 12 months	th period
	nissions to hospital for treatment of infective respirato	ry exacerbations within a 12 month period
Note: Indications marked with * are unapproved indications.		
Renewal — non-cystic fibrosis bronchiectasis*		
Current approval Number (if known):		
Applications only from a respiratory specialist or particle patient must not have had more than 1 prior a		
Prerequisites(tick boxes where appropriate)		
The patient has completed 12 mon	ths of azithromycin treatment for non-cystic fibrosis b	pronchiectasis
Following initial 12 months of treat	tment, the patient has not received any further azithmeths, unless considered clinically inappropriate to stop	
and  The patient will not receive more the	nan a total of 24 months' azithromycin cumulative trea	atment (see note)
Note: No further renewals will be subsidised. A m	aximum of 24 months of azithromycin treatment for n	on-cystic fibrosis bronchiectasis will be subsidised.

# APPLICATION FOR WAIVER OF RULE BY SPECIAL AUTHORITY

Page 106 **Form SA1857** 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:	
Initial application — Mycobacterial infections	ctious disease specialist or paediatrician. Approvals	valid for 2 years.	
Atypical mycobacterial infection or  Mycobacterium tuberculosis infection where there is drug-resistance or intolerance to standard pharmaceutical agents			
Initial application — Helicobacter pylori eradication Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)			
For the eradication of helicobacter pylori in a patient unable to swallow tablets  and  For use only in combination with omeprazole and amoxicillin as part of a triple therapy regimen			
Initial application — Prophylaxis of infective endocarditis Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick box where appropriate)  Prophylaxis of infective endocarditis associated with surgical or dental procedures if amoxicillin is contra-indicated			
	,		
Renewal — Mycobacterial infections			
Current approval Number (if known):  Applications only from a respiratory specialist, infe  Prerequisites(tick box where appropriate)	ctious disease specialist or paediatrician. Approvals	valid for 2 years.	
The treatment remains appropriate and t	he patient is benefiting from treatment		

# APPLICATION FOR MANUFACTURERS PRICE BY SPECIAL AUTHORITY

Page 107 **Form SA1355** 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:
Minocycline hydrochloride Tab 50 mg		
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)		
The patient has rosacea		

## APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 108 Form SA1332 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: Tetracycline		Fax Number:
Initial application Applications from any relevant practitioner. Approvals valid for 3 months.  Prerequisites(tick boxes where appropriate)		
For the eradication of helicobacter pylori following unsuccessful treatment with appropriate first-line therapy		
For use only in combination with bismuth as part of a quadruple therapy regimen		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 109 **Form SA1740** 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:		
Initial application — Tuberculosis Applications only from a respiratory specialist or in Prerequisites (tick boxes where appropriate)  Active tuberculosis*  and  Documented resistance resistance, as part of or  Impaired visual acuity or  Significant pre-existing or  Significant documented resistance resistance resistance resistance acuity or  Mycobacterium avium-intracellular or	de to one or more first-line medications to one or more first-line medications (tuberculosis as regimen containing other second-line agents (considered to preclude ethambutol use) g liver disease or hepatotoxicity from tuberculosis medications (tuberculosis as regimen containing other second-line agents ed intolerance and/or side effects following a reasonal ecomplex not responding to other therapy or where sand has had close contact with a confirmed multi-drug	sumed to be contracted in an area with known dications ble trial of first-line medications such therapy is contraindicated.*		
Note: Indications marked with * are unapproved in	dications.			
Renewal  Current approval Number (if known):				
Initial application — Mycoplasma genitalium  Applications only from a sexual health specialist or Practitioner on the recommendation of a sexual health specialist. Approvals valid for 1 month.  Prerequisites(tick boxes where appropriate)				
and  Has nucleic acid amplification test  Has tried and failed to clear	(NAAT) confirmed Mycoplasma genitalium* and is sy infection using azithromycin	mptomatic		
or Has laboratory confirmed az				
and Treatment is only for 7 days				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 110 **Form SA1740** 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:		
Moxifloxacin - continued				
Initial application — Penetrating eye injury Applications only from an ophthalmologist. Approvals valid for 1 month.  Prerequisites(tick box where appropriate)				
The patient requires prophylaxis following a penetrating eye injury and treatment is for 5 days only				

Note: Indications marked with \* are unapproved indications.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 111 Form SA1328 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 Num	ber:		Fax Number:			
Pyrimethamine						
Applicat	Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)					
O	<del></del> .	in patients with HIV for a period of 3 months				
0	For pregnant patients for the term	of the pregnancy				
	For infants with congenital toxopla	smosis until 12 months of age				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 112 Form SA1331 June 2025

Address:         DOB:         Address:           Address:         Address:         Fax Number:							
Address:							
Fax Number: Fax Nu							
Fax Number:							
Fax Number:							
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  For the treatment of toxoplasmosis in patients with HIV for a period of 3 months							
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  For the treatment of toxoplasmosis in patients with HIV for a period of 3 months  or							
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  For the treatment of toxoplasmosis in patients with HIV for a period of 3 months  or	Sulfadiazine						
or							
or							
For infants with congenital toxoplasmosis until 12 months of age							

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 113 Form SA1689 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:	
Paromomycin			
Initial application Applications only from an infectious disease special Prerequisites(tick boxes where appropriate)  Patient has confirmed cryptosporidition  For the eradication of Entamoeba h		rovals valid for 1 month.	
Renewal  Current approval Number (if known):			
Patient has confirmed cryptosporidi	ium infection		
For the eradication of Entamoeba h	nistolyica carriage		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 114 Form SA1359 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	lo:	First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
	umber:onazole oral liquid		Fax Number:	
Appli	al application — Systemic candidiasis cations from any relevant practitioner. Approxequisites(tick boxes where appropriate)	vals valid for 6 weeks.		
	Patient requires prophylaxis for, or  Patient is unable to swallow capsu			
Appli	Initial application — Immunocompromised Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)			
	Patient is immunocompromised  and Patient is at moderate to high risk and Patient is unable to swallow capsu	-		
Rene	ewal — Systemic candidiasis			
	ent approval Number (if known):			
	cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)	rals valid for 6 weeks.		
	Patient requires prophylaxis for, or and Patient is unable to swallow capsu	•		
Renewal — Immunocompromised				
	ent approval Number (if known):			
	cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)	rals valid for 6 months.		
	Patient remains immunocompromi	sed		
	Patient remains at moderate to hig	h risk of invasive fungal infection		
	Patient is unable to swallow capsu	les		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 115 Form SA1322 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:	
Itraconazole			
Initial application Applications only from an infectious disease specialist, clinical microbiologist, clinical immunologist or any relevant practitioner on the recommendation of a infectious disease physician, clinical microbiologist or clinical immunologist. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)  The patient has a congenital immune deficiency			
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick box where appropriate)			
The treatment remains appropriate and the patient is benefitting from the treatment			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 116 Form SA2384 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:		
Voriconazole				
Initial application — invasive fungal infection Applications only from a haematologist, infectious Prerequisites(tick boxes where appropriate)	disease specialist or clinical microbiologist. Approval	s valid for 3 months.		
Patient is immunocompromised				
	ary team including an infectious disease specialist			
	ole invasive aspergillus infection			
Patient has possible invasive	e aspergillus infection			
or Patient has fluconazole resis	stant candidiasis			
or Patient has mould strain suc	h as Fusarium spp. and Scedosporium spp			
Renewal — invasive fungal infection  Current approval Number (if known):	disease specialist or clinical microbiologist. Approval	s valid for 3 months.		
Patient is immunocompromised				
Applicant is part of a multidisciplin	ary team including an infectious disease specialist			
	treatment for proven or probable invasive aspergillus	infection		
	treatment for possible invasive aspergillus infection			
Patient has fluconazole resis	stant candidiasis			
Patient has mould strain suc	ch as Fusarium spp. and Scedosporium spp			
Initial application — Invasive fungal infection prophylaxis Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)				
The patient is at risk of invasive fungal infection				
	y, or recommended by a haematologist, transplant pl oncologist	nysician, infectious disease specialist, paediatric		
	n accordance with a protocol or guideline that has be pecific settings where there is a greater than 10% risk			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 117 Form SA2384 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:		
Voriconaz	cole - continued				
Renewal —	- Invasive fungal infection prophylax	is			
Current app	Current approval Number (if known):				
	s from any relevant practitioner. Approv tes(tick boxes where appropriate)	als valid for 6 months.			
and	The patient is at risk of invasive fu	ngal infection			
	Voriconazole is prescribed by haematologist or paediatric or	y, or recommended by a haematologist, transplant ploncologist	nysician, infectious disease specialist, paediatric		
	Prescribing voriconazole is i	n accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te becific settings where there is a greater than 10% risk of invasive fungal infection (IFI)			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 118 Form SA2383 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:
Posaconazole		
or	s disease specialist. Approvals valid for 6 weeks.  nia and is to be treated with high dose remission indu  ansplant and has graft versus host disease and is on	
Patient has received a stem cell tragoing posaconazole treatment  Note: * Graft versus host disease (GVHD) on sign they were being treated with intensive immunosupp	s disease specialist. Approvals valid for 6 weeks.  nia and is to be treated with high dose remission industrial and has graft versus host disease and is on difficant immunosuppression is defined as acute GVHE pressive therapy consisting of either high-dose cortices mg or greater per kilogram every other day for patie	significant immunosuppression* and requires on  O, grade II to IV, or extensive chronic GVHD, or if osteroids (1 mg or greater per kilogram of body
Initial application — Invasive fungal infection p Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)		
The patient is at risk of invasive fur	ngal infection	1
or paediatric haematologist or paediatric pa	by, or recommended by a haematologist, transplant poaediatric oncologist in accordance with a protocol or guideline that has becific settings where there is a greater than 10% risk	een endorsed by the Health New Zealand - Te
	<u> </u>	5 , ,

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 119 Form SA2383 June 2025

APPL	ICAN	<b>T</b> (sta	amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:	
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umber	r:			Fax Number:
Posa	cona	azol	e - continued		
Renewal — Invasive fungal infection prophylaxis					
Current approval Number (if known):					
			m any relevant practitioner. Appr	ovals valid for 6 months.	
Prerequisites(tick boxes where appropriate)					
	and		The patient is at risk of invasive f	ungal infection	
		or	Posaconazole is prescribe paediatric haematologist o	d by, or recommended by a haematologist, transplant prepared procedures on the procedure of	physician, infectious disease specialist,
		O.		is in accordance with a protocol or guideline that has be specific settings where there is a greater than 10% risk	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 120 Form SA1684 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:	
Primaquine			
Initial application Applications only from an infectious disease special Prerequisites(tick boxes where appropriate)  The patient has vivax or ovale maland Primaquine is to be given for a management.		onth.	
Renewal  Current approval Number (if known):			
The patient has relapsed vivax or ovale malaria  and Primaquine is to be given for a maximum of 21 days			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 121 **Form SA2234** 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:		
Linezolid				
Initial application — multi-drug resistant tuberculosis Applications from any relevant practitioner. Approvals valid for 18 months.  Prerequisites(tick boxes where appropriate)				
The person has multi-drug resistar	nt tuberculosis (MDR-TB)			
	Dinical Network has reviewed the individual case and	recommends linezolid as part of the treatment		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 122 **Form SA2244** 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:
Bedaquiline		
Initial application — multi-drug resistant tubero Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)		
The person has multi-drug resistar	nt tuberculosis (MDR-TB)	
	linical Network has reviewed the individual case and	recommends bedaquiline as part of the

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 123 Form SA1685 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:	
Lamivudine			
Initial application Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 1 year.  Prerequisites(tick box where appropriate)			
Used for the treatment or prevention of h	epatitis B		
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid for 2 years.		
Used for the treatment or prevention of hepatitis B			

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 124 Form SA1993 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:
Valganciclovir		
Initial application — transplant cytomegalovirus Applications only from a relevant specialist. Appro Prerequisites(tick box where appropriate)  The patient has undergone a solid organization.		nylaxis
prophylaxis  and  Patient is to receive a maxin  or		anti-thymocyte globulin
and	num of 90 days of valganciclovir prophylaxis following	
Initial application — cytomegalovirus prophyla Applications only from a relevant specialist. Appre Prerequisites(tick boxes where appropriate)		
and	an transplant and received valganciclovir under Spec	
Renewal — cytomegalovirus prophylaxis follo	wing anti-thymocyte globulin	
Current approval Number (if known):		
Applications only from a relevant specialist. Appropriet Prerequisites (tick box where appropriate)	ovals valid for 3 months.	
The patient has received a further cours	e of anti-thymocyte globulin and requires valganciclo	rir for CMV prophylaxis

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 125 Form SA1993 June 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No: First Names: First Names: First Names:		
Name: Surname: Surname:		
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Valganciclovir - continued		
Initial application — Lung transplant cytomegalovirus prophylaxis Applications only from a relevant specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Patient has undergone a lung transplant  and  The donor was cytomegalovirus positive and the patient is cytomegalovirus negative  or  The recipient is cytomegalovirus positive  and  Patient has a high risk of CMV disease		
Initial application — Cytomegalovirus in immu Applications only from a relevant specialist. Appro Prerequisites(tick boxes where appropriate)  Patient is immunocompromised and		
	syndrome or tissue invasive disease	
or Patient has rapidly rising pla	isma CMV DNA in absence of disease	
Patient has cytomegalovirus	retinitis	
Renewal — Cytomegalovirus in immunocompr	omised nationts	
Current approval Number (if known):		
Applications only from a relevant specialist. Appro	ovals valid for 3 months.	
Patient is immunocompromised and		
Patient has cytomegalovirus	syndrome or tissue invasive disease	
	isma CMV DNA in absence of disease	
Patient has cytomegalovirus	retinitis	

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 126 Form SA2138 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:	
Emtricitabine with tenofovir disoproxil			
Initial application Applications from any relevant practitioner. Approvals valid for 24 months.  Prerequisites(tick boxes where appropriate)  Patient has tested HIV negative, does not have signs or symptoms of acute HIV infection and has been assessed for HIV seroconversion and  The Practitioner considers the patient is at elevated risk of HIV exposure and use of PrEP is clinically appropriate  Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines: https://ashm.org.au/HIV/PrEP/			
Renewal  Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid for 24 months.  Prerequisites(tick boxes where appropriate)			
Patient has tested HIV negative, do	pes not have signs or symptoms of acute HIV infection	n and has been assessed for HIV seroconversion	
	ent is at elevated risk of HIV exposure and use of Pr	EP is clinically appropriate	
Note: Refer to local health pathways or the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine clinical guidelines:			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 127 **Form SA2139** 

		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:	
Antiretrovirals			
Initial application — Confirmed HIV Applications only from a named specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient has confirmed HIV infection Note: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.  Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.			
Renewal — Confirmed HIV  Current approval Number (if known):			
Initial application — Prevention of maternal transmission Applications only from a named specialist. Approvals valid for 1 year.  Prerequisites(tick boxes where appropriate)  Prevention of maternal foetal transmission or Treatment of the newborn for up to eight weeks			
Note: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.  Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.  Some antiretrovirals are unapproved or contraindicated for this indication. Practitioners prescribing these medications should exercise their own skill, judgement, expertise and discretion, and make their own prescribing decisions with respect to the use of a Pharmaceutical for an indication for which it is not approved or contraindicated.			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 128 Form SA2139 June 2025

APPLI	CAN	IT (st	amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	o:			First Names:	First Names:
Name:			Surname:	Surname:	
Addres	s:			DOB:	Address:
				Address:	
Fax Nu	ımbe	er:			Fax Number:
Antir	etro	vira	ls - continued		
Applic	ation	ns fro	ion — post-exposure prophylaxis om any relevant practitioner. Approv tick boxes where appropriate)		
	and		Treatment course to be initiated wi	thin 72 hours post exposure	
			Patient has had condomless or detectable viral load great	anal intercourse or receptive vaginal intercourse with	h a known HIV positive person with an unknown
		or	Patient has shared intraveno	ous injecting equipment with a known HIV positive pe	rson
		or	Patient has had non-consent required	sual intercourse and the clinician considers that the r	isk assessment indicates prophylaxis is
		or	Patient has had condomless is unknown	anal intercourse with a person from a high HIV preva	alence country or risk group whose HIV status
a boo antire	ster trovii	eithe als.	er as part of a combination product	iretroviral medications. The combination of a proteas or separately) will be counted as one protease inhibit Society for HIV, Viral Hepatitis and Sexual Health Me	
			cond or subsequent post-exposu		
Applic	atio	ns fro	om any relevant practitioner. Approvitick boxes where appropriate)		
	and		Treatment course to be initiated wi	thin 72 hours post exposure	
			Patient has had condomless or detectable viral load great	anal intercourse or receptive vaginal intercourse with	h a known HIV positive person with an unknown
		or	Patient has shared intravend	ous injecting equipment with a known HIV positive pe	rson
		or	Patient has had non-consent required	sual intercourse and the clinician considers that the r	risk assessment indicates prophylaxis is
		or	Patient has had condomless is unknown	anal intercourse with a person from a high HIV preva	alence country or risk group whose HIV status
Applic	atio	ns on	ion — Percutaneous exposure lly from a named specialist. Approv tick box where appropriate)	als valid for 6 weeks.	
Subsi a boo	The patient has percutaneous exposure to blood known to be HIV positive  Note: Tenofovir disoproxil prescribed under endorsement for HIV is included in the count of up to 4 subsidised antiretrovirals.  Subsidies apply for a combination of up to four antiretroviral medications. The combination of a protease inhibitor and low-dose ritonavir given as a booster (either as part of a combination product or separately) will be counted as one protease inhibitor for the purpose of accessing funding to antiretrovirals.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 129 **Form SA2139** 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:			
Antiretrovirals - continued					
Renewal — Second or subsequent percutaneous exposure					
Current approval Number (if known):					
Applications only from a named specialist. Approvals valid for 6 weeks.  Prerequisites(tick box where appropriate)					
The patient has percutaneous exposure to blood known to be HIV positive					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 130 Form SA2034 June 2025

APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:	First Names:	First Names:	
Name:	Name: Surname: Surnam		
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Pegylated Interferon alfa-2A			
Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant Applications from any specialist. Approvals valid for 18 months.  Prerequisites(tick boxes where appropriate)  Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection  or  Patient has chronic hepatitis C and is co-infected with HIV  or  Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant  and			
Renewal — Chronic hepatitis C - genotype 1 infection  Current approval Number (if known):			
Patient has chronic hepatitis C, go	enotype 1		
Patient has had previous treatmen	nt with pegylated interferon and ribavirin		
Patient has responder relap	osed		
Patient was a partial respon	nder		
and Patient is to be treated in combina	ation with boceprevir		
Maximum of 48 weeks therapy			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 131 Form SA2034 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:
Pegylated Interferon alfa-2A - continued		
Applications only from a gastroenterologist, infection in the prerequisites (tick boxes where appropriate)  Patient has chronic hepatitis C, geand	t with pegylated interferon and ribavirin sed der reatment prior to 2004	
Initial application — chronic hepatitis C - geno Applications from any specialist. Approvals valid for Prerequisites (tick boxes where appropriate)	type 2 or 3 infection without co-infection with HIV or 12 months.	
Patient has chronic hepatitis C, ge	notype 2 or 3 infection	
and Maximum of 6 months therapy		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 132 Form SA2034 June 2025

APPLICAN	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	er:		Fax Number:	
Pegylate	ed Interferon alfa-2A - continued			
Applicatio	plication — Hepatitis B ons only from a gastroenterologist, infection sites(tick boxes where appropriate)	ous disease specialist or general physician. Approval	s valid for 18 months.	
and		infection (HBsAg positive for more than 6 months)		
and	Patient is Hepatitis B treatment-na	ive		
and	ALT > 2 times Upper Limit of Norm	nal		
and	HBV DNA < 10 log10 IU/ml			
	HBeAg positive			
	Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)			
	and Compensated liver disease			
	and No continuing alcohol abuse or intravenous drug use			
anc	and Not co-infected with HCV, HIV or HDV			
and	Neither ALT nor AST > 10 times up	oper limit of normal		
and		ntraindications to pegylated interferon		
and				
Initial application — myeloproliferative disorder or cutaneous T cell lymphoma Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)				
or	Patient has a cutaneous T cell lym	phoma*		
	Patient has a myeloproliferat	tive disorder*		
	Patient is intolerant of hydrox	xyurea		
	and Treatment with anagrelide an	nd busulfan is not clinically appropriate		
or				
	Patient has a myeloproliferat			
	Patient is pregnant, planning pregnancy or lactating			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 133 **Form SA2034** 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:
Pegylated Interferon alfa-2A - continued		
Patient has a cutaneous T c  or  Patient has a cutaneous T c  Patient has a myelopr  and  Remains intoler  or	vals valid for 12 months.  on  e and patient is benefitting from treatment  ell lymphoma*  oliferative disorder*  ant of hydroxyurea and treatment with anagrelide and ant, planning pregnancy or lactating	d busulfan remains clinically inappropriate
Initial application — post-allogenic bone marro Applications from any relevant practitioner. Approx Prerequisites(tick box where appropriate)  Patient has received an allogeneic bone		upse
Renewal — post-allogenic bone marrow transp		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	zais vaiiu ior 3 montris.	
Patient is responding and ongoing treatm Note: Indications marked with * are unapproved in		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 134 Form SA2406 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:	
Fosfomycin			
and  Microbiological testing confination amoxicillin with clavulanic actions.  The patient has a contrainding and actions.	rns the pathogen is resistant to all of: trimethoprim, r	nitrofurantoin, amoxicillin, cefaclor, cefalexin,	
Renewal  Current approval Number (if known):			
Patient has an acute, symptomatic	, bacteriologically-proven uncomplicated urinary tract	infection (UTI)/cystitis with Escherichia Coli	
Microbiological testing confii amoxicillin with clavulanic ac	rms the pathogen is resistant to all of: trimethoprim, roid, and norfloxacin	nitrofurantoin, amoxicillin, cefaclor, cefalexin,	
	cation or intolerance to all of: trimethoprim, nitrofurar floxacin that the pathogen is susceptible to	ntoin, amoxicillin, cefaclor, cefalexin, amoxicillin	

**Musculoskeletal System** 

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 136 Form SA1289 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:	
Capsaicin			
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)			
The patient has osteoarthritis that is not responsive to paracetamol and oral non-steroidal anti-inflammatories are contraindicated			

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 137 Form SA1779 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:
equal to 2.5 standard deviations be History of one significant osteopore cannot be performed because of many patients under 75 years of ag  History of two significant osteopore or  Documented T-Score less than or or	otic fracture demonstrated radiologically and docume elow the mean normal value in young adults (i.e. T-S otic fracture demonstrated radiologically, and either the najor logistical, technical or pathophysiological reasonge otic fractures demonstrated radiologically equal to -3.0 (see Notes)	core less than or equal to -2.5) (see Notes) ne patient is elderly, or densitometry scanning ns. It is unlikely that this provision would apply to

#### Note:

- a) BMD (including BMD used to derive T-Score) must be measured using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable.
- b) Evidence suggests that patients aged 75 years and over who have a history of significant osteoporotic fracture demonstrated radiologically are very likely to have a T-Score less than or equal to -2.5 and, therefore, do not require BMD measurement for raloxifene funding.
- c) Osteoporotic fractures are the incident events for severe (established) osteoporosis, and can be defined using the WHO definitions of osteoporosis and fragility fracture. The WHO defines severe (established) osteoporosis as a T-score below -2.5 with one or more associated fragility fractures. Fragility fractures are fractures that occur as a result of mechanical forces that would not ordinarily cause fracture (minimal trauma). The WHO has quantified this as forces equivalent to a fall from a standing height or less.
- d) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 138 **Form SA1139** 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:	
Teriparatide			
Initial application Applications from any relevant practitioner. Approvals valid for 18 months.  Prerequisites(tick boxes where appropriate)			
The patient has severe, established osteoporosis			
The patient has a documented T-score less than or equal to -3.0 (see Notes)			
The patient has had two or more fractures due to minimal trauma			
	st one symptomatic new fracture after at least 12 moses (see Notes)	onths' continuous therapy with a funded	

#### Note:

- a) The bone mineral density (BMD) measurement used to derive the T-score must be made using dual-energy x-ray absorptiometry (DXA). Quantitative ultrasound and quantitative computed tomography (QCT) are not acceptable
- b) Antiresorptive agents and their adequate doses for the purposes of this Special Authority are defined as: alendronate sodium tab 70 mg or tab 70 mg with colecalciferol 5,600 iu once weekly; raloxifene hydrochloride tab 60 mg once daily; zoledronic acid 5 mg per year. If an intolerance of a severity necessitating permanent treatment withdrawal develops during the use of one antiresorptive agent, an alternate antiresorptive agent must be trialled so that the patient achieves the minimum requirement of 12 months' continuous therapy.
- c) A vertebral fracture is defined as a 20% or greater reduction in height of the anterior or mid portion of a vertebral body relative to the posterior height of that body, or a 20% or greater reduction in any of these heights compared to the vertebral body above or below the affected vertebral body.
- d) A maximum of 18 months of treatment (18 cartridges) will be subsidised.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 139 **Form SA2441** 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:
Denosumab		
or  History of one significant oste scanning cannot be performed or  History of two significant oste or  Documented T-Score less the or  A 10-year risk of hip fracture BMD measured using DEXA	eoporotic fracture demonstrated radiologically, with a ured using dual-energy x-ray absorptiometry (DEXA) eoporotic fracture, demonstrated radiologically, and ed because of logistical, technical or pathophysiological eoporotic fractures demonstrated radiologically an or equal to -3.0 greater than or equal to 3%, calculated using a publication of the properties of the pr	either the patient is elderly, or densitometry cal reasons ished risk assessment algorithm that incorporates
or The patient has experienced	at least two symptomatic new fractures or a BMD loopy with a funded antiresorptive agent	
or Intravenous bisphosphonates	s cannot be administered due to logistical or technica	al reasons
Initial application — Hypercalcaemia Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  Patient has hypercalcaemia of malignancy and Patient has severe renal impairment		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 140 Form SA1963 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:
Benzbromarone		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvals valid for 2 years.		
Prerequisites(tick boxes where appropriate)		
The treatment remains appropriate	and the patient is benefitting from the treatment	
There is no evidence of liver toxicity and patient is continuing to receive regular (at least every three months) liver function tests		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 141 Form SA2054 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:	
Febuxostat			
Initial application — Gout Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient has been diagnosed with gout and The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose or The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose or The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol (see Note)  The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.			
Prerequisites(tick boxes where appropriate)			
Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome			
Patient has a documented history of allopurinol intolerance			
Renewal — Gout  Current approval Number (if known):			
Renewal — Tumour lysis syndrome			
Current approval Number (if known):			
Applications only from a haematologist or oncolog <b>Prerequisites</b> (tick box where appropriate)	ist. Approvals valid for 6 weeks.		
The treatment remains appropriate and the patient is benefitting from treatment			

#### **Nervous System**

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 143 Form SA1403 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:
Riluzole		
and	Il sclerosis with disease duration of 5 years or less tof predicted forced vital capacity within 2 months pricacheostomy espiratory failure	or to the initial application
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approval Prerequisites (tick boxes where appropriate)		
The patient has not undergone a train and The patient has not experienced re	•	
The patient is ambulatory  or  The patient is able to use upport	per limbs	
The patient is able to swallow	N	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 144 Form SA0906 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:
Topical local anaesthetics (EMLA; LMX4)		
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick box where appropriate)	als valid for 2 years.	
The patient is a child with a chronic medi	cal condition requiring frequent injections or venepur	octure
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	als valid for 2 years.	
The treatment remains appropriate and the	ne patient is benefiting from treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 145 Form SA2088 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:
Vigabatrin		
or Seizures are contreatment with or Patient has tuberous scleros  and Patient is, or will be, receiving thereafter)	t adequately controlled with optimal treatment with ot ntrolled adequately but the patient has experienced ι ther antiepilepsy agents	e starting therapy and on a 6-monthly basis
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv		
Prerequisites(tick boxes where appropriate)		
The patient has demonstrated a sig	gnificant and sustained improvement in seizure rate of	or severity and or quality of life
Patient is receiving regular a with vigabatrin	utomated visual field testing (ideally every 6 months)	on an ongoing basis for duration of treatment
	e (due to comorbid conditions) to monitor the patient's	s visual fields.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 146 **Form SA2267** 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:
Lacosamide		
following: sodium valproate, topira	rals valid for 15 months.  folled by, or patient has experienced unacceptable sidmate, levetiracetam and any two of carbamazepine, ared to trial phenytoin sodium, sodium valproate, or to	amotrigine and phenytoin sodium (see Note)
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	rals valid for 24 months.	
The patient has demonstrated a significatory to starting lacosamide treatment	nt and sustained improvement in seizure rate or seve	erity and/or quality of life compared with that prior

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 147 **Form SA2268** 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:
Stiripentol		
Prerequisites(tick boxes where appropriate)  Patient has confirmed diagnosis of and Seizures have been inadequately of topiramate, levetiracetam, ketogen	controlled by appropriate courses of sodium valproate	e, clobazam and at least two of the following:
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvemental Prerequisites (tick box where appropriate)	als valid without further renewal unless notified.	
The patient continues to benefit from trea	atment as measured by reduced seizure frequency fro	om baseline

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 148 Form SA1998 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:	
Hyoscine (Scopolamine)			
Initial application Applications Applications from any relevant practitioner. Approvals valid for 1 year.  Prerequisites(tick boxes where appropriate)  Control of intractable nausea, vomiting, or inability to swallow saliva in the treatment of malignancy or chronic disease where the patient cannot tolerate or does not adequately respond to oral anti-nausea agents  Control of clozapine-induced hypersalivation where trials of at least two other alternative treatments have proven ineffective			
Renewal  Current approval Number (if known):	als valid for 1 year.		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 149 Form SA0987 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:	
Aprepitant			
Initial application Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick box where appropriate)  The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy			
The patient is undergoing highly emeloge	enic chemotherapy and/or antinacycline-based chem	otherapy for the treatment of mangnancy	
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approv <b>Prerequisites</b> (tick box where appropriate)	vals valid for 12 months.		
The patient is undergoing highly emetogenic chemotherapy and/or anthracycline-based chemotherapy for the treatment of malignancy			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 150 **Form SA2397** June 2025

APPL	ICAN	NT (stamp	or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg I	No:			First Names:	First Names:
Name	e:			Surname:	Surname:
Addre	ess: .			DOB:	Address:
				Address:	
	lumbe	er:			Fax Number:
Appl	icatio	sites(tick b	The patient has schizophren  Has not been able to adhere	vals valid for 12 months.  cial Authority approval for paliperidone depot injection ia or other psychotic disorder  e with treatment using oral atypical antipsychotic ager al or treated in respite care, or intensive outpatient or	nts
Curr	icatio	ns from an	mber (if known):y relevant practitioner. Approvox where appropriate)		
				on has been associated with fewer days of intensive i atypical antipsychotic depot injection	ntervention than was the case during a corresponding

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 151 **Form SA2313** 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:
Olanzapine depot injection		
Renewal		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid for 12 months.	
The initiation of olanzapine depot injectic period of time prior to the initiation of an		ntervention than was the case during a corresponding

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 152 **Form SA2395** June 2025

APPLICANT (stamp or sticker acceptable)  Reg No:  Name:  Address:	PATIENT NHI:	REFERRER Reg No:
Fax Number:  Aripiprazole		Fax Number:
or The patient has schized and The patient has received and The patient has been a 30 days or more in lass and the patient has been and the patient has been unable to access have been started on olanzapine depotent of the patient has had an initial Special Authority.  All of the following:  The patient has schizophrenia; and  The patient has not been able to adhere with the patient has not been able to adhere with the patient has not been able to adhere with the patient has schizephrenia.	I Special Authority approval for risperidone depot injection or other psychotic disorder ed treatment with oral atypical antipsychotic agents be admitted to hospital or treated in respite care, or interest 12 months  olanzapine depot injection due to supply issues with epot injection but has been unable to due to supply is nority criteria that apply to criterion 2 in this Aripiprazo approval for paliperidone depot injection or risperidor the treatment using oral atypical antipsychotic agents; and the treatment using oral atypical antipsychotic agents.	out has been unable to adhere asive outpatient or home-based treatment for olanzapine depot injection, or otherwise would asues with olanzapine depot injection ale Special Authority application are as follows: the depot injection; or
The patient has been admitted to hospital or 12 months.	r treated in respite care, or intensive outpatient or hor	ne-based treatment for 30 days or more in the last

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 153 Form SA2396 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:
Paliperidone depot injection		
or  depot injection  The patient has schizophrer and  Has been unable to adhere	vals valid for 12 months.  cial Authority approval for risperidone depot injection of the psychotic disorder to treatment using oral atypical antipsychotic agents all or treated in respite care, or intensive outpatient or	
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)		
	ion has been associated with fewer days of intensive initiation of an atypical antipsychotic depot injection	intervention than was the case during a

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 154 **Form SA2167** 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:	
Paliperidone palmitate			
Initial application Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has schizophrenia  The patient has had an initial Special Authority approval for paliperidone once-monthly depot injection			
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)			
	ion has been associated with fewer days of intensive	intervention than was the case during a	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 155 **Form SA2274** June 2025

LICANT (star	mp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
eg No:		First Names:	. First Names:	
e:		Surname:	. Surname:	
ess:		DOB:	. Address:	
		Address:		
			. Fax Number:	
tiple Scler				
alizumab and lications from	on — Multiple Scierosis - dimediate discrete dimediate di any relevant practitioner. Appock boxes where appropriate)	ethyl fumarate, fingolimod, glatiramer acetate, intervals valid for 12 months.	erteron beta-1-alpha, interteron beta-1-beta,	
and	Diagnosis of multiple scle neurologist	rosis (MS) meets the McDonald 2017 diagnostic crite	eria for MS and has been confirmed by a	
and	Patient has an EDSS sco	re between 0 – 6.0		
and	Patient has had at least o	ne significant attack of MS in the previous 12 months	or two significant attacks in the past 24 months	
	necessarily have be features were chara and  Each significant atte experienced symptom and	ack is associated with characteristic new symptom(s)/	st/physician must be satisfied that the clinical sign(s) or substantially worsening of previously	
	attack (where relevent and Each significant attack)  and 37.5°C)	ant) ack can be distinguished from the effects of general fa	atigue; and is not associated with a fever (T>	
	or System score  Each signification	ant attack is severe enough to change either the EDS es by at least 1 point  ant attack is a recurrent paroxysmal symptom of multi ermitte's symptom)		
and				
and	Evidence of new inflamma	atory activity on an MRI scan within the past 24 month	ns	
	A sign of that new i lesion	nflammatory activity on MRI scanning (in criterion 5 in	mmediately above) is a gadolinium enhancing	
	A sign of that new i	nflammatory activity is a lesion showing diffusion rest	riction	
	or A sign of that new i	nflammatory is a T2 lesion with associated local swell	ling	
		nflammatory activity is a prominent T2 lesion that clea	arly is responsible for the clinical features of a	
	or	nflammatory activity is new T2 lesions compared with	a previous MRI scan	
		, ,		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 156 **Form SA2274** 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:	
Multiple Sclerosis - continued			
Renewal — Multiple Sclerosis - dimethyl fumarate, fingolimod, glatiramer acetate, interferon beta-1-alpha, interferon beta-1-beta, natalizumab and teriflunomide			
Current approval Number (if known):			
Applications from any relevant practitioner. Approv <b>Prerequisites</b> (tick box where appropriate)	als valid for 12 months.		
Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use of unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months)  Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 157 **Form SA2273** June 2025

PPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
eg No:		First Names:	First Names:	
me:		Surname:	Surname:	
dress:		DOB:	Address:	
		Address:		
Number:			Fax Number:	
relizumab				
plications fron	on — Multiple Sclerosis - ocr n any relevant practitioner. App ck boxes where appropriate)			
and	neurologist	erosis (MS) meets the McDonald 2017 diagnostic cr	iteria for MS and has been confirmed by a	
and	Patient has an EDSS sco	re between 0 – 6.0		
and	Patient has had at least of	one significant attack of MS in the previous 12 month	ns or two significant attacks in the past 24 months	
anu	Each significant att	ack must be confirmed by the applying neurologist of een seen by them during the attack, but the neurologacteristic)		
	and  Each significant attack is associated with characteristic new symptom(s)/sign(s) or substantially worsening of previous experienced symptoms(s)/sign(s)  and			
	Each significant attack has lasted at least one week and has started at least one month after the onset of attack (where relevant)		least one month after the onset of a previous	
	and	ack can be distinguished from the effects of general	fatigues and is not appointed with a favor /Tx	
	37.5°C)	ack can be distinguished from the effects of general	ratigue, and is not associated with a lever (1)	
	Each signific System scor	ant attack is severe enough to change either the ED	SS or at least one of the Kurtze Functional	
		ant attack is a recurrent paroxysmal symptom of mu ermitte's symptom)	Itiple sclerosis (tonic seizures/spasms, trigeminal	
and	Cuidenes of new inflorma	otovu ostivitu on on MDI soon within the nest 24 may	atha	
and	Evidence of new inflamm	atory activity on an MRI scan within the past 24 mor	าเกร	
	lesion	inflammatory activity on MRI scanning (in criterion 5	immediately above) is a gadolinium enhancing	
	A sign of that new	inflammatory activity is a lesion showing diffusion re	striction	
	or  A sign of that new inflammatory is a T2 lesion with associated local swelling or  A sign of that new inflammatory activity is a prominent T2 lesion that clearly is responsible for the clinical features of			
		occurred within the last 2 years	carry to responsible for the chilical leatures of a	
		inflammatory activity is new T2 lesions compared wi	th a previous MRI scan	
or				
	Patient has an active Special A nterferon beta-1-beta, natalizu	uthority approval for either dimethyl fumarate, fingoli nab or teriflunomide	mod, glatiramer acetate, interferon beta-1-alpha,	
		e sclerosis treatments simultaneously is not permitte	ed.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 158 Form **SA2273** 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:  Ocrelizumab - continued		Fax Number:		
Renewal — Multiple Sclerosis - ocrelizumab				
Current approval Number (if known):				
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid for 12 months.			
Patient has had an EDSS score of 0 to 6.0 (inclusive) with or without the use of unilateral or bilateral aids at any time in the last six months (ie the patient has walked 100 metres or more with or without aids in the last six months)  Note: Treatment on two or more funded multiple sclerosis treatments simultaneously is not permitted.				
Initial application — Primary Progressive Multi Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)				
Diagnosis of primary progressive r	nultiple sclerosis (PPMS) meets the 2017 McDonald	criteria and has been confirmed by a neurologist		
	qual to or greater than 2 on pyramidal functions) to E	DSS 6.5		
Patient has no history of relapsing	remitting multiple sclerosis			
B				
Renewal — Primary Progressive Multiple Scler				
Current approval Number (if known):				
Prerequisites(tick box where appropriate)				
Patient has had an EDSS score of less the assistance/aids, without rest in the last s	han or equal to 6.5 at any time in the last six months ix months)	(ie patient has walked 20 metres with bilateral		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 159 Form SA1386 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:		
Phenobarbitone				
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
For the treatment of terminal agita	tion that is unresponsive to other agents			
	iplinary team working in palliative care			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 160 **Form SA1666** 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:	
Melatonin			
Initial application Applications only from a psychiatrist, paediatrician, paediatrician, neurologist or respiratory specialist.  Prerequisites(tick boxes where appropriate)	neurologist, respiratory specialist or medical practition Approvals valid for 12 months.	oner on the recommendation of a psychiatrist,	
Patient has been diagnosed with persistent and distressing insomnia secondary to a neurodevelopmental disorder (including, limited to, autism spectrum disorder or attention deficit hyperactivity disorder)*  Behavioural and environmental approaches have been tried and were unsuccessful, or are inappropriate  and  Funded modified-release melatonin is to be given at doses no greater than 10 mg per day  Patient is aged 18 years or under*			
Renewal			
Current approval Number (if known):			
Patient is aged 18 years or under*			
	meaningful benefit from funded modified-release me	elatonin (clinician determined)	
persistent and distressing insomnia	odified-release melatonin discontinuation within the p	past 12 months and has had a recurrence of	
Funded modified-release melatoning	n is to be given at doses no greater than 10 mg per d	ay	

Note: Indications marked with \* are unapproved indications.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 161 **Form SA2174** 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:		
Nusinersen				
and mutation Patient is 18 years of age or under and	als valid for 12 months.  of homozygous SMN1 gene deletion, homozygous S  defined signs and symptoms of SMA type I, II or IIIa			
Renewal — spinal muscular atrophy (SMA)  Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)				
There has been demonstrated maintenance of motor milestone function since treatment initiation  Patient does not require invasive permanent ventilation (at least 16 hours per day) in the absence of a potentially reversible cause while being treated with nusinersen  Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 162 Form SA2203 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:
Risdiplam		
Initial application — spinal muscular atrophy (SMA) Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites (tick boxes where appropriate)  Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMI mutation  Patient is 18 years of age or under  and  Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior  Patient is pre-symptomatic  and  Patient has three or less copies of SMN2		
Renewal — spinal muscular atrophy (SMA)  Current approval Number (if known):		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 163 **Form SA2415** 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:
Prerequisites (tick boxes where appropriate)  Patient is currently on treatment wor  ADHD (Attention Deficit and and Diagnosed according to DS and  Applicant is a paediat or Applicant is a medica consulted within the later and has not received or Patient is taking a cur effective due to significant cor Patient is taking a cur release) which has not received or	M-V or ICD 11 criteria	paediatrician or psychiatrist has been atient in writing  Iphenidate hydrochloride (extended-release) effects  e (immediate-release) which has not been ulties  ediate release dexamfetamine sulfate  ochloride (immediate-release or sustained or treatment adherence difficulties
but has been u	ave been prescribed a subsidised formulation of methodale to access due to supply issues with methylphen e stimulant presentations (methylphenidate or dexam	idate hydrochloride (extended-release)
and Lisdexamfetamine dimesilat	e is not to be used in combination with another funder	d methylphenidate presentation

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 164 Form SA2410 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:  Dexamfetamine Sulfate		Fax Number:	
	ears or over  , medical practitioner on the recommendation of a pain ian or psychiatrist (in writing). Approvals valid without		
ADHD (Attention Deficit and Hyper and Diagnosed according to DSM-IV o	ractivity Disorder) in patients aged 5 years or over		
or  Applicant is a paediatrician of Applicant is a medical practification within the last 2 years and here.	or psychiatrist tioner or nurse practitioner and confirms that a paedi as recommended treatment for the patient in writing	atrician or psychiatrist has been consulted	
Initial application — ADHD in patients aged under 5 years Applications only from a paediatrician or psychiatrist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)			
ADHD (Attention Deficit and Hyper and Diagnosed according to DSM-IV o	ractivity Disorder) in patients under 5 years of age		
Initial application — Narcolepsy Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient suffers from percelepsy.			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 165 Form SA2411 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:	
Methylphenidate Hydrochloride (Rubifen	Rubifen SR; Ritalin; Methylphenidate ER - Teva)		
Initial application — ADHD in patients aged 5 years or over  Applications only from a paediatrician, psychiatrist, medical practitioner on the recommendation of a paediatrician or psychiatrist (in writing). Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  ADHD (Attention Deficit and Hyperactivity Disorder) in patients aged 5 years or over  and  Diagnosed according to DSM-IV or ICD 10 criteria  and  Applicant is a paediatrician or psychiatrist  or  Applicant is a medical practitioner or nurse practitioner and confirms that a paediatrician or psychiatrist has been consulted within the last 2 years and has recommended treatment for the patient in writing			
Initial application — ADHD in patients aged under 5 years Applications only from a paediatrician or psychiatrist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)			
and Diagnosed according to DSM-IV o	ractivity Disorder) in patients under 5 years of age		
Initial application — Narcolepsy*  Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient suffers from narcolepsy  Note: *narcolepsy is not a registered indication for Methylphenidate ER – Teva.			

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 166 Form SA2450

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	r		Fax Number:	
Methylph	enidate Hydrochloride Exten	ded Release (Concerta; Ritalin LA)		
Application practitioner		n, medical practitioner on the recommendation of a pacian or psychiatrist (in writing). Approvals valid without Hyperactivity Disorder)		
	Diagnosed according to DS	M-IV or ICD 10 criteria		
		rician or psychiatrist  I practitioner or nurse practitioner and confirms that a ast 2 years and has recommended treatment for the p		
		rently subsidised formulation of methylphenidate hyd ffective due to significant administration and/or difficu		
		ncern regarding the risk of diversion or abuse of imm	rediate-release methylphenidate hydrochloride	
or				
	Patient meets the Special A	uthority criteria for SA2411 methylphenidate hydrochl	oride	
	Patient is unable to access out of stock (see note)	other methylphenidate hydrochloride presentations u	nder Special Authority criteria SA2411 due to an	
Note: Criterion 2 is to permit short-term funding to cover an out-of-stock on tab extended-release Methylphenidate ER – Teva and tab sustained-release methylphenidate				
Application Prerequisi	Initial application — Narcolepsy* Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient suffers from narcolepsy Note: *narcolepsy is not a registered indication for Concerta or Ritalin LA.			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 167 **Form SA2451** June 2025

APPLICAN	<b>IT</b> (stan	np or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:			Surname:	Surname:
Address:			DOB:	Address:
			Address:	
				Fax Number:
Modafini	il			
Initial application Applications only from a neurologist or respiratory specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  The patient has a diagnosis of narcolepsy and has excessive daytime sleepiness associated with narcolepsy or daily for three months or more  The patient has a multiple sleep latency test with a mean sleep latency of less than or equal to 10 minute sleep onset rapid eye movement periods  or  The patient has at least one of: cataplexy, sleep paralysis or hypnagogic hallucinations  and  An effective dose of a subsidised formulation of methylphenidate or dexamfetamine has been trialled and because of intolerable side effects  Methylphenidate and dexamfetamine are contraindicated		associated with narcolepsy occurring almost ess than or equal to 10 minutes and 2 or more allucinations		
Or Note: Critical	Patient meets the Special Authority criteria for methylphenidate hydrochloride or methylphenidate hydrochloride extended-release for narcolepsy and Patient is unable to access methylphenidate hydrochloride presentations due to an out of stock (see note)  Note: Criterion 2 is to permit short-term funding to cover an out-of-stock of methylphenidate hydrochloride or methylphenidate hydrochloride extended			
note: Crit release.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 168 Form SA1488 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:		
Rivastigmine patches				
Initial application Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  The patient has been diagnosed with dementia and The patient has experienced intolerable nausea and/or vomiting from donepezil tablets				
Renewal				
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)				
The treatment remains app	ropriate			
and The patient has demonstrated	ted a significant and sustained benefit from treatment			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 169 Form SA1408 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:	
Naltrexone			
Initial application Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient is currently enrolled in a recognised comprehensive treatment programme for alcohol dependence and Applicant works in or with a community Alcohol and Drug Service contracted to Health NZ or accredited against the New Zealand Alcohol and Other Drug Sector Standard or the National Mental Health Sector Standard			
Renewal			
Current approval Number (if known):			
Compliance with the medication (p	rescriber determined)		
Patient is still unstable and r	equires further treatment		
-	improvement but requires further treatment		
or Patient is well controlled but	requires maintenance therapy		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 170 **Form SA1845** June 2025

APPLICA	NT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No: .		First Names:	First Names:
Name:		Surname:	Surname:
Address:		DOB:	Address:
		Address:	
Fax Numb	er:		Fax Number:
	line tartrate		
	aximum of 12 weeks' varenicline will be so les the 4-week 'starter' pack.	ubsidised on each Special Authority approval.	
	plication ons from any relevant practitioner. Approv sites(tick boxes where appropriate)	rals valid for 5 months.	
and		nieving abstinence in a patient who has indicated tha	t they are ready to cease smoking
and	The patient is part of, or is about to prescriber or nurse monitoring	enrol in, a comprehensive support and counselling	smoking cessation programme, which includes
	The patient has tried but failed to quit smoking after at least two separate trials of nicotine replacement therapy, at least one of which included the patient receiving comprehensive advice on the optimal use of nicotine replacement therapy  The patient has tried but failed to quit smoking using bupropion or nortriptyline		
	and The patient has not had a Special Authority for varenicline approved in the last 6 months and		
and	Varenicline is not to be used in combination with other pharmacological smoking cessation treatments and the patient has agreed to this and		
anı	The patient is not pregnant and		
		nore than 12 weeks' funded varenicline (see note)	
Renewal			
	pproval Number (if known):		
The patie	ons from any relevant practitioner. Approvent must not have had an approval in the p		
Prerequi	sites(tick boxes where appropriate)		
and	_ <del></del>	nieving abstinence in a patient who has indicated tha	t they are ready to cease smoking
	prescriber or nurse monitoring	enrol in, a comprehensive support and counselling	smoking cessation programme, which includes
and	It has been 6 months since the pat	ient's previous Special Authority was approved	
and	Varenicline is not to be used in con	nbination with other pharmacological smoking cessat	ion treatments and the patient has agreed to this
and	The patient is not pregnant		
		nore than 12 weeks' funded varenicline (see note)	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 171 **Form SA1203** 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:	
Buprenorphine with naloxone			
Initial application — Detoxification Applications from any medical practitioner. Approvals valid for 1 month.  Prerequisites(tick boxes where appropriate)  Patient is opioid dependent  and Patient is currently engaged with an opioid treatment service approved by the Ministry of Health  Applicant works in an opioid treatment service approved by the Ministry of Health.			
Applications from any medical practitioner. Approx Prerequisites(tick boxes where appropriate)	vals valid for 12 months.	1	
Patient is opioid dependent  and Patient will not be receiving methadone			
and Patient is currently enrolled in an opioid substitution treatment program in a service approved by the Ministry of Health			
and Applicant works in an opioid treatment service approved by the Ministry of Health			
Renewal — Detoxification			
Current approval Number (if known):			
Applications from any medical practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	als valid for 1 month.		
Patient is opioid dependent			
Patient has previously trialled but the attempt is planned	ailed detoxification with buprenorphine with naloxone	with relapse back to opioid use and another	
Patient is currently engaged with a	an opioid treatment service approved by the Ministry of	of Health	
	nent service approved by the Ministry of Health		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 172 Form SA1203 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:
Buprenorphine with naloxone - continued	1	
Renewal — Maintenance treatment		
Current approval Number (if known):		
Applications from any medical practitioner. Approv  Prerequisites(tick boxes where appropriate)	als valid for 12 months.	
Patient is currently enrolled in an o	aintenance therapy with buprenorphine with naloxone	he Ministry of Health
to manage treatment in this patient	nent service approved by the Ministry of Health or is a t	a medical practitioner authorised by the service
Renewal — Maintenance treatment where the p	atient has previously had an initial application fo	r detoxification
Current approval Number (if known):		
Applications from any medical practitioner. Approv <b>Prerequisites</b> (tick boxes where appropriate)	als valid for 12 months.	
Patient received but failed detoxific	cation with buprenorphine with naloxone	
	rphine with naloxone is planned (and patient will not	be receiving methadone)
Patient is currently enrolled in an o	pioid substitution program in a service approved by the	he Ministry of Health
	nent service approved by the Ministry of Health	

Oncology Agents and Immunosuppressants

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 174 Form SA2398 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:Bendamustine hydrochloride		Fax Number:
Initial application — CLL*	relevant practitioner on the recommendation of a rele	vant specialist. Approvals valid for 12 months.
The patient has chronic lymphocyl	tic leukaemia requiring treatment	
Patient has ECOG performance st	tatus of 0-2	
Bendamustine is to be administered	ed at a maximum dose of 100 mg/m² on days 1 and 2	every 4 weeks for a maximum of 6 cycles
Note: Indication marked with a * includes indication (SLL).	ns that are unapproved. 'Chronic lymphocytic leukae	emia (CLL)' includes small lymphocytic lymphoma
Prerequisites(tick boxes where appropriate)  The patient has indolent low grade	relevant practitioner on the recommendation of a rele	vant specialist. Approvals valid for 9 months.
The patient has ECOG performan	ce status of 0-2	
Patient is treatment no and		ation with rituaireah when CD20
or	e administered for a maximum of 6 cycles (in combina	ation with rituximab when GD20+)
	or has relapsed within 12 months of a rituximab con	taining combined chemo-immunotherapy
	e administered in combination with obinutuzumab for	a maximum of 6 cycles
and Bendamustine is to be	eceived prior bendamustine therapy e administered for a maximum of 6 cycles in relapsed	patients (in combination with rituximab when
and Patient has had a ritu:	ximab treatment-free interval of 12 months or more	
or Bendamustine is to be admi	nistered as monotherapy for a maximum of 6 cycles i	n rituximab refractory patients

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 175 **Form SA2398** June 2025

APPLICANT (stamp or sticker acceptable)		or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name	):			Surname:	Surname:
Addre	ess:			DOB:	Address:
				Address:	
Fax N	lumbe	r:			Fax Number:
Bend	damı	ıstine l	nydrochloride - continued	1	
Curr Appl	ent ap	proval Nu	nt, Low-grade lymphomas umber (if known): om a relevant specialist or any poxes where appropriate)	relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 9 months.
	Patient is refractory to or has relapsed within 12 months of rituximab in combination with bendamustine  and  Bendamustine is to be administered in combination with obinutuzumab for a maximum of 6 cycles  or				
	Patients have not received a bendamustine regimen within the last 12 months  Bendamustine is to be administered for a maximum of 6 cycles in relapsed patients (in combination with rituximab when CD20+)  and  Patient has had a rituximab treatment-free interval of 12 months or more				
		o		e administered as a monotherapy for a maximum of 6	cycles in rituximab refractory patients
Note: 'indolent, low-grade lymphomas' includes follicular, mantle cell, marginal zone and lymphoplasmacytic/ Waldenstrom's macroglobulinaemia.					
Initial application — Hodgkin's lymphoma* 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 Hodgkin's lymphoma requiring treatment				
	Patient has a ECOG performance status of 0-2				
	Patient has received one prior line of chemotherapy				
	Patient's disease relapsed or was refractory following prior chemotherapy				
	and [	90 r	mg/m2 twice per cycle, for a m	<u> </u>	BeGeV) at a maximum dose of no greater than
Note	: Indic	cations m	arked with * are unapproved ir	ndications.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 176 **Form SA1725** 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:
Mercaptopurine		
Initial application Applications only from a paediatric haematologist or paediatric oncologist. Approvals valid for 12 months.  Prerequisites(tick box where appropriate)		
The patient requires a total dose of less than one full 50 mg tablet per day		
Renewal		
Current approval Number (if known):		
Applications only from a paediatric haematologist of <b>Prerequisites</b> (tick box where appropriate)	or paediatric oncologist. Approvals valid for 12 month	is.
Patient still requires a total dose of less than one full 50 mg tablet per day		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 177 **Form SA2479** 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:
Azacitidine		
Initial application Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The individual has intermediate or high risk MDS based on an internationally recognised scoring system  or  The individual has chronic myelomonocytic leukaemia (based on an intermediate or high risk score from an internationally recognised scoring system or 10%-29% marrow blasts without myeloproliferative disorder)  The individual has acute myeloid leukaemia according to World Health Organisation Classification (WHO)  and  The individual has an estimated life expectancy of at least 3 months		
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approvement of the properties of the prop	rals valid for 12 months.	

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 178 Form SA2356 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:	
Thalidomide			
Initial application Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick box where appropriate)			
The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment			
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)			
The patient has obtained a response from	n treatment during the initial approval period		

Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier. Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 179 **Form SA2275** 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:
Temozolomide		
Initial application — gliomas Applications only from a relevant specialist. Appro Prerequisites(tick box where appropriate)  The patient has a glioma	vals valid for 12 months.	
Renewal — gliomas		
Current approval Number (if known):		
Applications only from a relevant specialist. Appro <b>Prerequisites</b> (tick box where appropriate)	vals valid for 12 months.	
Treatment remains appropriate and patie	ant is benefitting from treatment	
Initial application — neuroendocrine tumours Applications only from a relevant specialist. Appro Prerequisites(tick boxes where appropriate)	vals valid for 9 months.	
Patient has been diagnosed with metastatic or unresectable well-differentiated neuroendocrine tumour*  and  Temozolomide is to be given in combination with capecitabine		
and Temozolomide is to be used in 28 day treatment cycles for a maximum of 5 days treatment per cycle at a maximum dose of 200 mg/m² per day		
Temozolomide to be discontinued at disease progression		
Renewal — neuroendocrine tumours		
Current approval Number (if known):		
Applications only from a relevant specialist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)		
No evidence of disease progression		
The treatment remains appropriate	e and the patient is benefitting from treatment	
Initial application — ewing's sarcoma Applications only from a relevant specialist. Appro Prerequisites(tick box where appropriate)		
The patient has relapsed/refractory Ewin	g's sarcoma	

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 180 Form SA2275 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:	
Temozolomide - continued			
Renewal — ewing's sarcoma			
Current approval Number (if known):			
Applications only from a relevant specialist. Approvals valid for 6 months.			
Prerequisites(tick boxes where appropriate)			
No evidence of disease progression			
The treatment remains appropriate	and the patient is benefitting from treatment		

Note: Indication marked with a  $^{\star}$  is an unapproved indication. Temozolomide is not subsidised for the treatment of relapsed high grade glioma.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 181 **Form SA2355** 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:	
Bortezomib			
Initial application — plasma cell dyscrasia Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)			
The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 182 Form SA1979 June 2025

APPLIC	ANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No	·	First Names:	First Names:
Name:		Surname:	Surname:
Address	:	DOB:	Address:
		Address:	
Fax Nur	nber:		Fax Number:
Pegas	pargase		
Initial application — Acute lymphoblastic leukaemia Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  The patient has newly diagnosed acute lymphoblastic leukaemia			
Pegaspargase to be used with a contemporary intensive multi-agent chemotherapy treatment protocol			
Initial application — Lymphoma Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.  Prerequisites(tick box where appropriate)  The patient has lymphoma requiring L-asparaginase containing protocols (e.g. SMILE)			
Renew	ral — Acute lymphoblastic leukaemia		
Curren	t approval Number (if known):		
	ations only from a relevant specialist or mediuisites(tick boxes where appropriate)	ical practitioner on the recommendation of a relevant	specialist. Approvals valid for 12 months.
ē	The patient has relapsed acute lym  Pegaspargase to be used with a co	nphoblastic leukaemia ontemporary intensive multi-agent chemotherapy trea	atment protocol

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 183 Form SA2481 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:		
	7,001030.		
		Fax Number:	
Venetoclax			
Initial application — relapsed/refractory chroni Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)			
Individual has chronic lymphocytic	leukaemia requiring treatment		
	e prior therapy for chronic lymphocytic leukaemia		
and Individual has not previously receiv	ved funded venetoclax		
and The individual's disease has relap:	sed		
	· — ·		
venetoclax and			
Individual has an ECOG performa	nce status of 0-2		
Renewal — relapsed/refractory chronic lymphocytic leukaemia  Current approval Number (if known):			
	priate and the individual is benefitting from and tolera	ating treatment	
Venetoclax is to be discontinued after a maximum of 24 months of treatment following the titration schedule unless earlier discontinuation is required due to disease progression or unacceptable toxicity			
Initial application — previously untreated chron Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	nic lymphocytic leukaemia with 17p deletion or Tl vals valid for 6 months.	P53 mutation*	
Individual has previously untreated	d chronic lymphocytic leukaemia		
There is documentation confirming that individual has 17p deletion by FISH testing or TP53 mutation by sequencing			
Individual has an ECOG performance status of 0-2			
Renewal — previously untreated chronic lympl	hocytic leukaemia with 17p deletion or TP53 muta	tion*	
Current approval Number (if known):			
Applications from any relevant practitioner. Approx	als valid for 6 months.		
Prerequisites(tick box where appropriate)			
	iate and the patient is benefitting from and tolerating to des small lymphocytic lymphoma (SLL)* and B-cell p		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 184 Form SA2481 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:
Venetoclax - continued		
Individual has previously unto Classification and Venetoclax not to be used in and		ing to World Health Organization (WHO)
Renewal — previously untreated acute myeloid Current approval Number (if known):	als valid for 6 months. sion coma*	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 185 **Form SA2163** 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: Olaparib			Fax Number:
Prerequisites(tick boxes when and Patient has a	ical oncologist or medere appropriate) high-grade serous* 6	cical practitioner on the recommendation of a relevant	cancer
and Fand Fand Fand Fand Fand Fand Fand F	Patient has received or Patient's disease mus Patient has received a Patient has platinum she penultimate line**	gnosed, advanced disease one line** of previous treatment with platinum-based of t have experienced a partial or complete response to at least two lines** of previous treatment with platinum sensitive disease defined as disease progression occu of platinum-based chemotherapy t have experienced a partial or complete response to en	the first-line platinum-based regimen  a-based chemotherapy  urring at least 6 months after the last dose of
and Treatment wil	ll be commenced with	usly received funded olaparib treatment  nin 12 weeks of the patient's last dose of the immedian	tely preceding platinum-based regimen
Treatment not	t to be administered i	n combination with other chemotherapy	

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 186 Form SA2163 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:
Prerequisites (tick boxes where appropriate)  Treatment remains clinically appropriate  No evidence of progressive of Evidence of residual (not promote and Treatment to be administered as mand Treatment not to be administered in and Patient has received of and Documentation confirm olaparib will not be come no radiological evidence or	criate and patient is benefitting from treatment disease gressive) disease and the patient would continue to be	benefit from treatment in the clinician's opinion  hemotherapy edges that the funded treatment period of omplete response to treatment and there is

Note: \*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.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 187 Form SA2480 June 2025

Reg No: First Names: First Names: Surname: Surname: Surname: Address: DOB: Address: Address: Address: Address: Fax Number: Fax Number: Fax Number: Fax Number: Fax Number: Morutinib  Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy Individual has not previously received funded ibrutinib and Ibrutinib is to be used as monotherapy and Individual has experienced intolerable side effects with venetoclax monotherapy or Individual has experienced intolerable side effects with venetoclax monotherapy or Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen		
Address:  Address:  Address:  Address:  Address:  Address:  Address:  Address:  Fax Number:  Fax Number:  Fax Number:  Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy  Individual has not previously received funded ibrutinib  and  Ibrutinib is to be used as monotherapy  and  There is documentation confirming that the individual has 17p deletion or TP53 mutation  and  Individual has experienced intolerable side effects with venetoclax monotherapy  or  Individual has received at least one prior immunochemotherapy for CLL  Individual's CLL has relapsed		
Fax Number: Fax Nu		
Fax Number: Fax Number: Fax Number: Ilbrutinib  Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy  Individual has not previously received funded ibrutinib  and Ibrutinib is to be used as monotherapy  There is documentation confirming that the individual has 17p deletion or TP53 mutation  Individual has experienced intolerable side effects with venetoclax monotherapy  or  Individual has received at least one prior immunochemotherapy for CLL  and Individual's CLL has relapsed		
Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy and Individual has not previously received funded ibrutinib and Ibrutinib is to be used as monotherapy and Individual has experienced intolerable side effects with venetoclax monotherapy  or Individual has received at least one prior immunochemotherapy for CLL and Individual's CLL has relapsed and		
Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy and Individual has not previously received funded ibrutinib and Ibrutinib is to be used as monotherapy and Individual has experienced intolerable side effects with venetoclax monotherapy  or Individual has received at least one prior immunochemotherapy for CLL and Individual's CLL has relapsed and		
Initial application — chronic lymphocytic leukaemia (CLL) Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy and Individual has not previously received funded ibrutinib and Ibrutinib is to be used as monotherapy and  There is documentation confirming that the individual has 17p deletion or TP53 mutation and Individual has experienced intolerable side effects with venetoclax monotherapy  or  Individual has received at least one prior immunochemotherapy for CLL and Individual's CLL has relapsed and		
Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy  Individual has not previously received funded ibrutinib  and  Ibrutinib is to be used as monotherapy  and  There is documentation confirming that the individual has 17p deletion or TP53 mutation  Individual has experienced intolerable side effects with venetoclax monotherapy  or  Individual has received at least one prior immunochemotherapy for CLL  and  Individual's CLL has relapsed  and		
Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Individual has chronic lymphocytic leukaemia (CLL) requiring therapy  and Individual has not previously received funded ibrutinib  and Ibrutinib is to be used as monotherapy  and There is documentation confirming that the individual has 17p deletion or TP53 mutation  and Individual has experienced intolerable side effects with venetoclax monotherapy  or Individual has received at least one prior immunochemotherapy for CLL  and Individual's CLL has relapsed  and		

marked with \* are Unapproved indications.

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 188 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		
and Patient has received at least one li and Patient has experienced a partial of and Patient has not previously received and Treatment will be commence or Patient commenced treatme and Treatment to be administered as mand	serous* epithelial ovarian, fallopian tube, or primary pone** of treatment with platinum-based chemotherapy or complete response to the preceding treatment with diffunded treatment with a PARP inhibitor and within 12 weeks of the patient's last dose of the print with niraparib prior to 1 May 2024	platinum-based chemotherapy
and  Treatment with niraparib to co	vals valid for 6 months.	

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

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 189 **Form SA2353** 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:
Lenalidomide		
Initial application — Plasma cell dyscrasia Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  Patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment  Patient is not refractory to prior lenalidomide use		
Initial application — Myelodysplastic syndrome Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient has low or intermediate-1 risk myelodysplastic syndrome (based on IPSS or an IPSS-R score of less than 3.5) associated with a deletion 5q cytogenetic abnormality  and Patient has transfusion-dependent anaemia		
Renewal — Myelodysplastic syndrome		
Current approval Number (if known):		
Applications from any relevant practitioner. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)		
Patient has not needed a transfusi		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 190 **Form SA2354** 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:
Pomalidomide		
Initial application — Relapsed/refractory plasm Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)		
Patient has relapsed or refractory p	olasma cell dyscrasia, not including Waldenström ma	croglobulinaemia, requiring treatment
Patient has not received prior fund	ed pomalidomide	
Renewal — Relapsed/refractory plasma cell dy	scrasia	
Current approval Number (if known):		
Applications from any relevant practitioner. Approvemental Prerequisites (tick box where appropriate)	rals valid for 12 months.	
There is no evidence of disease progress	sion	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 191 **Form SA2385** 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:
Dasatinib		
Prerequisites(tick boxes where appropriate)  The patient has a diagnosis of chror  The patient has a diagnosis of Phior  The patient has a diagnosis of Phior  Patient has document or  Patient has experience or	ner on the recommendation of a haematologist. Apponic myeloid leukaemia (CML) in blast crisis or accelerate ladelphia chromosome-positive acute lymphoid leukae of CML in chronic phase ed treatment failure* with imatinib ed treatment-limiting toxicity with imatinib precluding chronic-phase CML defined by the Sokal or EURO scenario.	erated phase nemia (Ph+ ALL)  further treatment with imatinib
Renewal		
Current approval Number (if known):		
Applications only from a haematologist or Practition Prerequisites (tick boxes where appropriate)	ner on the recommendation of a haematologist. App	rovals valid for 6 months.
Lack of treatment failure while on	dasatinib*	
Dasatinib treatment remains appro	priate and the patient is benefiting from treatment	
Note: *treatment failure for CML as defined by Lei	ukaemia Net Guidelines.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 192
Form SA2422 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:
Erlotinib		
and There is documentation confirming and Patient is treatment naive or Patient has received prior tre or The patient has discontant	als valid for 4 months.  stastatic, unresectable, non-squamous Non Small Ce that the disease expresses activating mutations of E satment in the adjuvant setting and/or while awaiting ntinued osimertinib or gefitinib due to intolerance agress while on osimertinib or gefitinib	EGFR
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)  Radiological assessment (preferably included)		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 193 **Form SA2452** 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:		
Sunitinib				
Initial application — RCC Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	vals valid for 4 months.			
The patient has metastatic renal c	ell carcinoma			
The patient has not previously rec	eived funded sunitinib			
Prerequisites(tick boxes where appropriate)	lical practitioner on the recommendation of a relevant			
and and	etastatic malignant gastrointestinal stromal tumour (G	ist)		
The patient's disease has pr	rogressed following treatment with imatinib			
	d treatment-limiting intolerance, or toxicity to, imatinib			
		,		
Renewal — RCC  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)				
There is no evidence of disease progres	sion			
Renewal — GIST  Current approval Number (if known):				
The patient has responded to treatme follows:	ent or has stable disease as determined by Choi's	modified CT response evaluation criteria as		
The patient has had a comp	lete response (disappearance of all lesions and no ne	ew lesions)		
	al response (a decrease in size of 10% or more or dec and no new lesions and no obvious progression of no			
	ase (does not meet criteria the two above) and does n mour progression	ot have progressive disease and no symptomatic		
and The treatment remains appropriate	e and the patient is benefiting from treatment			
Note: It is recommended that response to treatment be assessed using Choi's modified CT response evaluation criteria (J Clin Oncol, 2007, 25:1753-1759). Progressive disease is defined as either: an increase in tumour size of 10% or more and not meeting criteria of partial response (PR) by tumour density (HU) on CT; or: new lesions, or new intratumoral nodules, or increase in the size of the existing intratumoral nodules.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 194 **Form SA2452** 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:		
Sunitinib - continued				
Renewal — GIST pandemic circumstances				
Current approval Number (if known):				
Applications from any relevant practitioner. Approv <b>Prerequisites</b> (tick boxes where appropriate)	rals valid for 6 months.			
The patient has unresectable or mand	etastatic malignant gastrointestinal stromal (GIST)			
The patient is clinically benifiting from treatment and continued treatment remains appropriate				
Sunitinib is to be discontinued at p				
The regular Special Authority renewal requirements cannot be met due to COVID-19 constraints on the health sector				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 195 **Form SA2429** 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:
Pazopanib		
The patient has metastatic read and The patient has an ECOG per and The patient has intermediate or Lactate dehydrogenase or Haemoglobin level < loop The patient has interval of < 1 year from or	poor prognosis defined as: e level > 1.5 times upper limit of normal ower limit of normal um level > 10 mg/dL (2.5 mmol/L) m original diagnosis to the start of systemic therapy e score of less than or equal to 70	
and Pazopanib to be used for a n	naximum of 3 months	
The patient has metastatic real and The patient has discontinued and The cancer did not progress and Pazopanib to be used for a new control or and the cancer did not progress and	I sunitinib within 3 months of starting treatment due to whilst on sunitinib	o intolerance
Renewal  Current approval Number (if known):  Applications only from a relevant specialist or any representation of the properties o	relevant practitioner on the recommendation of a rele	vant specialist. Approvals valid for 3 months.

### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 196 **Form SA2423** 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:	
Gefitinib			
Patient is treatment naive  or  Patient has received prior tre  or  The patient has discor  and  The cancer did not pro  and	etastatic, unresectable, non-squamous Non Small Content in the adjuvant setting and/or while awaiting entinued osimertinib or erlotinib due to intolerance or	EGFR results	
Renewal Current approval Number (if known):			
, ,	Applications from any relevant practitioner. Approvals valid for 6 months.		
Prerequisites(tick box where appropriate)			
Radiological assessment (preferably incli	uding CT scan) indicates NSCLC has not progressed	r	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 197 Form SA2301 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:	
Nilotinib			
Patient has documented CMI	myeloid leukaemia (CML) in blast crisis, high risk chro L treatment failure* with a tyrosine kinase inhibitor (T tment limiting toxicity with a tyrosine kinase inhibitor day	KI)	
Renewal			
Current approval Number (if known):			
Applications only from a haematologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)			
Lack of treatment failure while on nilotinib as defined by Leukaemia Net Guidelines			
Nilotinib treatment remains appropr	riate and the patient is benefiting from treatment		
Maximum nilotinib dose of 800 mg/	day		
and Subsidised for use as monotherapy	only		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 198 Form SA1890 June 2025

APPLICANT (stamp or sticker acceptable)		amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umbei	r:			Fax Number:
Ruxo	litin	ib			
Initial application Applications only from a haematologist. Approvals of Prerequisites (tick boxes where appropriate)  The patient has primary myelofibros and  A classification of risk of interrection (IPSS), Dynamic International (IPSS), Dynamic International and		y from a haematologist. Approvals ick boxes where appropriate)  The patient has primary myelofibro  A classification of risk of inte (IPSS), Dynamic Internation:  A classification of risk (IPSS), Dynamic Internation (IPSS), Dy	rmediate-2 or high-risk myelofibrosis according to eital Prognostic Scoring System (DIPSS), or the Age-Adordinate-1 myelofibrosis according to either thational Prognostic Scoring System (DIPSS), or the Age-Adordinal Prognostic Scoring System (DIPSS), or the Age-Adordinate Prognostic Storing System (DIPSS), or the Age-Adordinate Prognostic Storing System (DIPSS), or the Age-Adordinate Prognostic Storing System (DIPSS), or the Age-Adordinate Prognosti	ther the International Prognostic Scoring System djusted DIPSS  The International Prognostic Scoring System Age-Adjusted DIPSS	
Renewal					
Current approval Number (if known):					
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)			specialist. Approvals valid for 12 months.		
The treatment remains appropriate		The treatment remains appropriate	and the patient is benefiting from treatment		
	and A maximum dose of 20 mg twice daily is to be given				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 199 Form SA1870 June 2025

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	:	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Alec	tinib		
Appli	Patient has locally advanced, or m	etastatic, unresectable, non-small cell lung cancer that the patient has an ALK tyrosine kinase gene re	
Appli	ent approval Number (if known):	dical practitioner on the recommendation of a relevan	nt specialist. Approvals valid for 6 months.
	and The patient is benefitting from and		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 200 **Form SA2345** 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:		
Palbociclib (Ibrance)				
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	rals valid for 6 months.			
	ally advanced or metastatic breast cancer			
and There is documentation conf	firming disease is hormone-receptor positive and HEI	R2-negative		
and Patient has an ECOG perfor	mance score of 0-2			
and		<del></del>		
or Disease has relapsed or progressed during prior endocrine therapy				
Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state				
and				
Patient has not	received prior systemic treatment for metastatic disea	ase		
and Treatment must be used in c	ombination with an endocrine partner			
and	or funded treatment with a CDK4/6 inhibitor			
or	i funded treatment with a CDR4/6 initibility			
	l Authority approval for ribociclib			
and Patient has experienced a gr	rade 3 or 4 adverse reaction to ribociclib that cannot	be managed by dose reductions and requires		
treatment discontinuation				
Treatment must be used in c	ombination with an endocrine partner			
There is no evidence of prog	ressive disease since initiation of ribociclib			
Current approval Number (if known):				
Current approval Number (if known):				
Prerequisites(tick boxes where appropriate)				
	Treatment must be used in combination with an endocrine partner			
There is no evidence of progressive disease since initiation of palbociclib				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 201 **Form SA2342** 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:		
Midostaurin				
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	Applications from any relevant practitioner. Approvals valid for 9 months.			
Patient has a diagnosis of acute my	yeloid leukaemia			
Condition must be FMS tyrosine kinase 3 (FLT3) mutation positive				
Patient must not have received a prior line of intensive chemotherapy for acute myeloid leukaemia				
Patient is to receive standard intens	only			
Midostaurin to be funded for a maximum of 4 cycles				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 202 **Form SA2343** June 2025

APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name:			Surname:	Surname:		
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumbei	r:				Fax Number:
Ribo	ciclil	b				
Appl		s from	any	relevant practitioner. Approxes where appropriate)	vals valid for 6 months.	
		and [	_		cally advanced or metastatic breast cancer	
		and	_		firming disease is hormone-receptor positive and HE	R2-negative
		and		Patient has an ECOG perfo	rmance score of 0-2	
			or	Disease has relapsed	or progressed during prior endocrine therapy	
	Patient is amen without menstru and Patient has not or Patient comments and Patient comments		without menstru	norrhoeic, either naturally or induced, with endocrine lual-potential state	levels consistent with a postmenopausal or	
			Patient has not	t received prior systemic endocrine treatment for metastatic disease		
			and	nced treatment with ribociclib in combination with an dence of progressive disease	endocrine partner prior to 1 July 2024	
		and	<u> </u>			
		and		Treatment to be used in con	mbination with an endocrine partner	
				Patient has not received price	or funded treatment with a CDK4/6 inhibitor	
	or Patient has an active Spec		Patient has an active Specia	al Authority approval for palbociclib		
		[		Patient has experienced a g treatment discontinuation	grade 3 or 4 adverse reaction to palbociclib that cannot	ot be managed by dose reductions and requires
		and [		Treatment must be used in	combination with an endocrine partner	
		and [		There is no evidence of pro-	gressive disease since initiation of palbociclib	
Ren	ewal					
Current approval Number (if known):						
Prerequisites (tick boxes where appropriate)						
	Treatment must be used in combina			nent must be used in combi	nation with an endocrine partner	
	and			is no evidence of progressiv	ve disease since initiation of ribociclib	
1						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 203 **Form SA2442** 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:
_envatinib		
or	als valid for 6 months.  th lenvatinib and met all remaining criteria prior to cornced or metastatic differentiated thyroid cancer	nmencing treatment
Patient must have sym  Patient must progressi cannot be achieved by  and  A lesion without iodine or Receiving cumulative I or Experiencing disease or Experiencing disease and Patient has thyroid stimulating and	e uptake in a RAI scan RAI greater than or equal to 600 mCi progression after a RAI treatment within 12 months progression after two RAI treatments administered within 12 months administered with a company to the company of the company with curative intent	
Patient has an ECOG perform	mance status of 0-2	
Renewal — thyroid cancer  Current approval Number (if known):	als valid for 6 months.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 204 **Form SA2442** 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:
Lenvatinib - continued		
or Patient has experience	rals valid for 6 months.  ellular carcinoma  n (Childs-Pugh A)  TACE) is unsuitable	-
Renewal — unresectable hepatocellular carcin		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	vals valid for 6 months.	
Transfer sex miles appropriate)		
There is no evidence of disease progress	sion	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 205 **Form SA2442** June 2025

APPLICAN	<b>IT</b> (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:		First Names:	First Names:	
Name:		Surname:	Surname:	
Address: .		DOB:	Address:	
		Address:		
Fax Number	ər:		Fax Number:	
Lenvatin	ib - continued			
Applicatio	and The patient has an ECOG pand Lenvatinib is to be used in compand Patient has received funded and Patient has experienced treand	renal cell carcinoma  ant clear-cell histology  d disease progression following one previous line of the performance status of 0-2  combination with everolimus  I treatment with nivolumab for the second line treatment atment limiting toxicity from treatment with nivolumab combination with everolimus		
	— renal cell carcinoma			
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick box where appropriate)				
There is no evidence of disease progression				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 206 Form SA2418 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:
Osimertinib		
Patient has locally advanced and  Patient is treatment in or Patient has received por  The patient has and There is documentation cord and Patient has an ECOG perform and Baseline measurement of or	rith osimertinib and met all remaining criteria prior to or door metastatic, incurable, non-squamous non-small or arive prior chemotherapy in the adjuvant setting and/or which discontinued gefitinib or erlotinib due to intolerance not progress while on gefitinib or erlotinib	cell lung cancer (NSCLC)  le awaiting EGFR results  s of EGFR
Renewal — NSCLC – first line  Current approval Number (if known):		
Current approval Number (if known):		
Prerequisites(tick box where appropriate)		
Response to or stable disease with treatment in target lesions has been determined by comparable radiologic assessment following the n recent treatment period		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 207 **Form SA2418** 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:
Osimertinib - continued		
Patient has locally advanced and Patient has an ECOG perfor and The patient must have received and There is documentation contection or gefitinib and The treatment must be given and	ith osimertinib and met all remaining criteria prior to or metastatic, incurable, non-squamous non-small or mance status 0-3 wed previous treatment with erlotinib or gefitinib firming that the cancer expresses T790M mutation of	EGFR following progression on or after
Renewal — NSCLC – second line		
Current approval Number (if known):		
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	als valid for 6 months.	
Response to treatment in target lesions h	nas been determined by comparable radiologic asses	sment following the most recent treatment period

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 208 **Form SA2458** 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:	
Axitinib			
Initial application Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has metastatic renal cell carcinoma and The disease is of predominant clear cell histology and The patient has documented disease progression following one previous line of treatment and The patient has ECOG performance status of 0-2			
Renewal  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)  There is no evidence of disease progress	vals valid for 4 months.		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 209 **Form SA2459** June 2025

APPLICANT (S	tamp 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:
Crizotinib			
	om any relevant practitioner. Approv (tick boxes where appropriate)  Patient has locally advanced or me There is documentation confirming Patient has ECOG performance so	stastatic, unresectable, non-squamous non-small cell that the patient has a ROS1 rearrangement using ar	n appropriate ROS1 test
Renewal	(al Number (if Impum))		
Applications fr	val Number (if known):om any relevant practitioner. Approv (tick boxes where appropriate)		
and	Response to treatment has been d	etermined by comparable radiological assessment fo	llowing the most recent treatment period

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 210 **Form SA2484** June 2025

APPLICANT (stamp or sticker acceptable)		ole)	PATIENT NHI:	REFERRER Reg No:			
Reg No:				F	First Names:	First Names:	
Name:				9	Surname:	Surname:	
Addre	ss:			ι	OOB:	Address:	
				/	Address:		
Fax N	umbei	r:				Fax Number:	
Dabr	afen	ib					
Appli	ication	ns from a	boxes where appro	oner. Approval priate)	noma - adjuvant Is valid for 4 months. ent with dabrafenib and trametinib and met all rema	uining criteria prior to commencing treatment	
			The individ	dual has resec	cted stage IIIB, IIIC, IIID or IV melanoma (excluding	uveal) (see note a)	
			and		nas received neoadjuvant treatment with a PD-1/PD-L1 inhibitor		
			Adju	uvani irealinei	nt with dabrafenib is required		
and Treatment must be adjuvant and			Treatment must	be adjuvant to	d prior funded systemic treatment in the adjuvant so complete surgical resection thin 13 weeks of surgical resection, unless delay is		
		and	note b)		BRAF mutation	necessary due to post surgery receivery (see	
		and	_ · · · · · · · · · · · · · · · · · · ·				
		and			red in combination with trametinib		
		L	The individual ha	as ECOG perf	ormance score 0-2		
Note	:						
	<ul><li>a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition</li><li>b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)</li></ul>						
Curre	ent app	proval N	, ,		······································		
			boxes where appro		ls valid for 4 months.		
	and	☐ No	evidence of disease	e recurrence			
	[	Da	brafenib must be ad	dministered in	combination with trametinib		
	[	and  Treatment to be discontinued at signs of disease recurrence or at completion of 12 months' total treatment course, including any systemic neoadjuvant treatment					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 211 **Form SA2484** June 2025

APPLICANT (stamp or sticker acceptable)		r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:
Name	Name:			Surname:	Surname:
Addre	ess:			DOB:	Address:
				Address:	
					Fax Number:
The individual has metastation and Baseline measurement of or and The individual has ECOG personal and Dabrafenib must be administed and The individual has been or The individual did not or The individual of and The indi		unresectable or metastatic relevant practitioner. Approxes where appropriate)  Individual is currently on treated the individual has metastatic baseline measurement of or the individual has ECOG per the individual has confirmed babrafenib must be administed.  The individual has been the individual of the individual o	ment with dabrafenib and trametinib and met all remains or unresectable melanoma (excluding uveal) stage werall tumour burden is documented clinically and radiate formance score 0-2.  BRAF mutation tered in combination with trametinib en diagnosed in the metastatic or unresectable stage receive treatment in the adjuvant setting with a BRAF eceived treatment in the adjuvant setting with a BRAF and not experience disease recurrence while on treatment in the experience disease recurrence within six montains.	III or IV iiologically  III or IV setting  F/MEK inhibitor  F/MEK inhibitor  ment with that BRAF/MEK inhibitor	
			table or metastatic melano		
Appl	ication	s from any	nber (if known):relevant practitioner. Approv xes where appropriate)		
	and [	or	The individual's disease has The individual has stable dis	had a complete response to treatment had a partial response to treatment lease with treatment sions has been determined by comparable radiologic	assessment following the most recent treatment

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 212 **Form SA2485** June 2025

APPLICANT (stamp or sticker acceptable)		(stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Addre	ess:		DOB:	Address:	
			Address:		
Fax N	lumber	·		Fax Number:	
Tran	etini	b			
Appl	ication	The individual has resonant and The individual has resonant and The individual has not received and		uveal) (see note a)  1 inhibitor	
		Treatment must be initiated note b)	within 13 weeks of surgical resection, unless delay is necessary due to post-surgery recovery (see		
		The individual has a confirm	ed BRAF mutation		
		Trametinib must be administ and	ered in combination with dabrafenib		
		The individual has ECOG pe	erformance score 0-2		
Note:  a) Stage IIIB, IIIC, IIID or IV melanoma defined as per American Joint Committee on Cancer (AJCC) 8th Edition  b) Initiating treatment within 13 weeks of complete surgical resection means 13 weeks after resection (primary or lymphadenectomy)					
Curr Appl	ent application	- stage III or IV resected melanoma - proval Number (if known):s from any relevant practitioner. Approvates (tick boxes where appropriate)			
	].	No evidence of disease recurrence			
	and [	Trametinib must be administered in	n combination with dabrafenib		
	and [	Treatment to be discontinued at sign systemic neoadjuvant treatment	gns of disease recurrence or at completion of 12 mor	nths' total treatment course, including any	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 213 **Form SA2485** June 2025

APPLICANT (stamp or sticker acceptable)		r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:
Name	Name:			Surname:	Surname:
Addre	ess:			DOB:	Address:
				Address:	
					Fax Number:
Initia Appl	al application	is from any ites (tick bo	unresectable or metastatic relevant practitioner. Approxes where appropriate)  Individual is currently on treated the individual has metastatic baseline measurement of or the individual has ECOG per the individual has confirmed to the individual has beautiful baseline to the individual has baseline to the individual has ba	ment with dabrafenib and trametinib and met all remains or or unresectable melanoma (excluding uveal) stage werall tumour burden is documented clinically and radiate formance score 0-2 displayed in the metastatic or unresectable stage receive treatment in the adjuvant setting with a BRAF ecceived treatment in the adjuvant setting with a BR	III or IV iologically  III or IV setting  F/MEK inhibitor  F/MEK inhibitor  ment with that BRAF/MEK inhibitor
Curr Appl	ent application	proval Num	table or metastatic melano nber (if known):relevant practitioner. Approx xes where appropriate)		
	and [	or	The individual's disease has The individual has stable dis	s had a complete response to treatment s had a partial response to treatment sease with treatment sions has been determined by comparable radiologic	assessment following the most recent treatment

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 214
Form SA2118 June 2025

APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:					First Names:	First Names:
Name:					Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbei	r:				Fax Number:
Abira	atero	ne a	ceta	te		
Appli radia	cation tion or	ncolog	from ist or	a medical oncologist, radia urologist. Approvals valid f es where appropriate)	tion oncologist, urologist or medical practitioner on the or 6 months.	e recommendation of a medical oncologist,
	and	P	atient	has prostate cancer		
	and	P	atient	has metastases		
	and [	P	atient	's disease is castration resi	stant	
		or	and and and	Patient has ECOG pe Patient has not had p  Patient's disease has Patient has ECOG pe	corogression (rising serum PSA) after second line anti-appropriate formance score of 0-1 rior treatment with taxane chemotherapy progressed following prior chemotherapy containing performance score of 0-2 rior treatment with abiraterone	
Curre Appli radia	ent appointment of the contraction approximation approximation approximation of the contraction approximation appr	proval is only ncolog	Numb from ist or	ne acetate  per (if known):  a medical oncologist, radia urologist. Approvals valid f es where appropriate)	tion oncologist, urologist or medical practitioner on the	e recommendation of a medical oncologist,
	[	s	Signific	cant decrease in serum PS	A from baseline	
	and [		lo evid	dence of clinical disease pr	ogression	
	and	N	lo initi	ation of taxane chemothera	apy with abiraterone	
	and		he tro	atmont romains appropriat	a and the nationt is benefiting from treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 215 **Form SA2118** 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:			
Abiraterone acetate - continued					
Renewal — pandemic circumstances					
Current approval Number (if known):					
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	als valid for 6 months.				
The patient is clinically benefiting from treatment and continued treatment remains appropriate					
	Abiraterone acetate to be discontinued at progression				
No initiation of taxane chemothera	py with abiraterone				
	wal requirements cannot be met due to COVID-19 co	onstraints on the health sector			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 216 Form SA1895 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:
Fulvestrant		
Prerequisites (tick boxes where appropriate)  Patient has oestrogen-receptor posential and Patient has disease progression folemetastatic disease	ical practitioner on the recommendation of a medical sitive locally advanced or metastatic breast cancer lowing prior treatment with an aromatase inhibitor or 500 mg monthly following loading doses lease progression	
Prerequisites(tick boxes where appropriate)	ical practitioner on the recommendation of a medical patient is benefitting from treatment	oncologist. Approvals valid for 6 months.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 217 **Form SA2445** 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:				
Long-acting Somatostatin Analogues						
and Treatment with antiemetics, rehydr successful		algesics for at least 48 hours has not been				
and Treatment to be given for up to 4 w	veeks					
Note: Indications marked with * are unapproved in						
Renewal — Malignant Bowel Obstruction  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick box where appropriate)  The treatment remains appropriate and t	vals valid for 3 months.					
Initial application — Acromegaly Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	vals valid for 3 months.					
The patient has acromegaly and						
Treatment with surgery and radiotherapy is not suitable or was unsuccessful  or  Treatment is for an interim period while awaiting the beneficial effects of radiotherapy						
and  Treatment with a dopamine agonist has been unsuccessful						
Renewal — Acromegaly						
Current approval Number (if known):						
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)						
IGF1 levels have decreased since starting treatment  Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have not decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 weeks						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 218 **Form SA2445** 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:  Long-acting Somatostatin Analogues		Fax Number:		
Initial application — pre-operative acromegaly Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)				
Patient has acromegaly  and Patient has a large pituitary tumou  and Patient is scheduled to undergo pit	r, greater than 10 mm at its widest uitary surgery in the next six months			
Initial application — Other Indications Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick boxes where appropriate)  VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery or  Gastrinoma  and Surgery has been unsuccessful  or Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful  or Insulinomas and Surgery is contraindicated or has not been successful  or Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)				
Note: The use of a long-acting somatostatin analo	trolled by maximal medical therapy gue in patients with fistulae, oesophageal varices, m	iscellaneous diarrhoea and hypotension will not be		
funded under Special Authority				
Renewal — Other Indications  Current approval Number (if known):				
The treatment remains appropriate and the	he patient is benefiting from treatment			

#### SA2399 - Etanercept

Authoritic sharpmaterid Denougl	000
Arthritis - rheumatoid - Renewal	
Arthritis - rheumatoid - Initial application	
Adult-onset Still's disease - Initial application	220
Adult-onset Still's disease - Renewal	220
Ankylosing spondylitis - Initial application	
Ankylosing spondylitis - Renewal	
Oligoarticular course juvenile idiopathic arthritis - Initial application	
Oligoarticular course juvenile idiopathic arthritis - Renewal	224
Polyarticular course juvenile idiopathic arthritis - Initial application	
Polyarticular course juvenile idiopathic arthritis - Renewal	223
Psoriatic arthritis - Initial application	225
Psoriatic arthritis - Renewal	226
Pyoderma gangrenosum - Initial application	226
Pyoderma gangrenosum - Renewal	226
Severe chronic plaque psoriasis - Initial application	229
Severe chronic plaque psoriasis - Renewal	230
Undifferentiated spondyloarthritis - Initial application	
Undifferentiated spondyloarthritis - Renewal	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 220 **Form SA2399** June 2025

APPLICANT (stamp or sticker acceptable)			p or sticker acceptable)	PATIENT NHI: REFERRER Reg No:		
Reg No:				First Names:	First Names:	
Name	e:			Surname:	Surname:	
Addre	ess:			DOB:	Address:	
				Address:		
Fax N	lumber	r:			Fax Number:	
Etan	erce	pt				
and  The patient has been s  and  The patient has experi			or The patient has been  The patient has been  The patient has been	Is valid for 6 months.  In initial Special Authority approval for adalimumab fo started on tocilizumab for AOSD in a Health NZ Hosp ienced intolerable side effects from adalimumab and/red insufficient benefit from at least a three-month trial	oital //or tocilizumab	
they do not meet the renewal criteria for AOSD  Patient diagnosed with AOSD according to the Yamaguchi criteria (J Rheumatol 1992;19:424-430)  and Patient has tried and not responded to at least 6 months of glucocorticosteroids at a dose of at least 0.5 mg/kg, non-s anti-inflammatory drugs (NSAIDs) and methotrexate  Patient has persistent symptoms of disabling poorly controlled and active disease					1992;19:424-430) at a dose of at least 0.5 mg/kg, non-steroidal	
Ren	Renewal — adult-onset Still's disease					
Appl	ication	s only f	Jumber (if known):rom a rheumatologist or Practition boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
		or [	Applicant is a rheumatologis Applicant is a Practitioner ar	it  nd confirms that a rheumatologist has provided a lette	er, email or fax recommending that the patient	
	and		continues with etanercept tre		,	
	The patient has a sustained improvement in inflammatory markers and functional status					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			acceptable)		PATIENT NHI:	REFERRER Reg No:			
Reg No:					First Names:	First Names:			
Name	):						Surname:	Surname:	
Addre	ess:						DOB:	Address:	
							Address:		
						-	, 60, 500		
								Fax Number:	
Etan	erce	pt - co	ntin	ued					
App	lication	ns only	fron	n a rhei	sing spondylitis umatologist. Approvere appropriate)	vals	s valid for 6 months.		
		and		The pa	tient has had an ini	itial	Special Authority approval for adalimumab for anky	losing spondylitis	
			or	$\overline{}$			rienced intolerable side effects from adalimumab ved insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for ankylosing		
		L		8	spondylitis				
	or								
		and		Patient	has a confirmed di	iagn	gnosis of ankylosing spondylitis present for more than six months  and stiffness that is relieved by exercise but not by rest		
				Patient	has low back pain	anc			
		and	٦	Patient	has hilateral sacro	iliitie	s demonstrated by plain radiographs, CT or MRI sca	an	
		and	_						
		L					litis has not responded adequately to treatment with two or more non-steroidal anti-inflammatory tion with anti-ulcer therapy if indicated, while patient was undergoing at least 3 months of a regular		
		and			e regimen for ankyl				
			or	E	Bath Ankylosing Spo	ond	f motion of the lumbar spine in the sagittal and the fi lylitis Metrology Index (BASMI) measures: a modified measurement of less than or equal to 10 cm (mear	ed Schober's test of less than or equal to 4 cm	
			٠.		Patient has limitation gender (see Notes)	n of	f chest expansion by at least 2.5 cm below the aver-	age normal values corrected for age and	
		and		A Bath	Ankylosing Spondy	ylitis	s Disease Activity Index (BASDAI) of at least 6 on a	0-10 scale	
mea Aver 18-2	sure m age no 4 year	nust be i ormal ch s - Male	no r est e: 7	nore th expans .0 cm; l		he ti	he completion of the 3 month exercise trial, but pricime of initial application. and gender:	r to ceasing NSAID treatment. The BASDAI	
35-4	4 year	s - Male	: 6	.5 cm; l	Female: 4.5 cm				
55-6	4 year	s - Male	: 5	.5 cm; l	Female: 5.0 cm Female: 4.0 cm				
65-74 years - Male: 4.0 cm; Female: 4.0 cm 75+ years - Male: 3.0 cm; Female: 2.5 cm									

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable) PATIENT NHI:	REFERRER Reg No:				
Reg No: First Names: First Names	s:				
Name: Surname: Surname:					
Address:					
Address:					
Fax Number: Fax Number	r:				
Etanercept - continued					
Renewal — ankylosing spondylitis					
Current approval Number (if known):					
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid	for 6 months.				
Prerequisites(tick boxes where appropriate)					
Applicant is a shoumatalogist					
or Applicant is a rheumatologist					
Applicant is a Practitioner and confirms that a rheumatologist has provided a letter, email or fa continues with etanercept treatment	x recommending that the patient				
and					
Following 12 weeks' initial treatment and for subsequent renewals, treatment has resulted in an imp points from pre-treatment baseline on a 10 point scale, or an improvement in BASDAI of 50%, which					
Physician considers that the patient has benefited from treatment and that continued treatment is ap	propriate				
and Etanercept to be administered at doses no greater than 50 mg every 7 days					
Lianercept to be administered at doses no greater than 50 mg every 7 days					
Initial application — polyarticular course juvenile idiopathic arthritis					
Applications only from a named specialist or rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)					
The patient has had an initial Special Authority approval for adalimumab for polyarticular cour	se juvenile idiopathic arthritis (JIA)				
The patient has experienced intolerable side effects from adalimumab					
or  The patient has received insufficient benefit from adalimumab to meet the renewal criter	ia for adalimumah for polyarticular				
course JIA					
or					
To be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate	is limited by toxicity or intolerance				
Patient has had polyarticular course JIA for 6 months duration or longer					
At least 5 active joints and at least 3 joints with limited range of motion, pain or tenderr	less after a 3-month trial of				
methotrexate (at the maximum tolerated dose)					
Moderate or high disease activity (cJADAS10 score of at least 2.5) after a 3-month trial tolerated dose)	of methotrexate (at the maximum				
or  Low disease activity (cJADAS10 score between 1.1 and 2.5) after a 6-month trial of me	hotrevate				
Low disease delivity (corrected score between 1.1 and 2.3) after a comortin trial of the	o.i oxalio				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name:			Surname:	Surname:		
Address:			DOB:	Address:		
	er:					
Renewal - Current ap Application valid for 6	— polyar  pproval Nons only from months.	ticular course juvenile idic		tion of a named specialist or rheumatologist. Approvals		
and	Subsidised as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count and continued improvement in physician's global assessment from baseline					
Application	ns only fi	boxes where appropriate)	eumatologist. Approvals valid for 6 months.			
	and	The patient has had an in	itial Special Authority approval for adalimumab	o for oligoarticular course juvenile idiopathic arthritis (JIA)		
	(	or	perienced intolerable side effects from adalimu	meet the renewal criteria for adalimumab for oligoarticular		
or	and _	- 1	to methotrexate therapy or monotherapy wher ular course JIA for 6 months duration or longer	re use of methotrexate is limited by toxicity or intolerance		
		maximum tolerated	dose)	rness after a 3-month trial of methotrexate (at the  1.5) with poor prognostic features after a 3-month trial of		
		methotrexate (at the	e maximum tolerated dose)  y (cJADAS10 score greater than 4) after a 6-m			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umber	:			Fax Number:
Etan	erce	<b>pt</b> - conti	inued		
Rene	wal –	– oligoart	ticular course juvenile idiop	athic arthritis	
Curre	ent app	oroval Nur	mber (if known):		
		s only fror nonths.	m a named specialist, rheuma	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
Prere	equisi	tes(tick bo	oxes where appropriate)		
	and j	Subs	sidised as an adjunct to metho	trexate therapy or monotherapy where use of methot	rexate is limited by toxicity or intolerance
		or	Following 3 to 4 months' init physician's global assessme	ial treatment, the patient has at least a 50% decrease on trom baseline	e in active joint count and an improvement in
		j. 🗆	% improvement in active joint count and		
			<u> </u>		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			r stick	ker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name:					Surname:	Surname:
Address	:				DOB:	Address:
					Address:	
Fax Nur	nber:					Fax Number:
Etaner	cept	conti	nued			
Applic: Prereq	ations o	d or	The paties or a recovery and a recovery was a recovery with the paties or a recovery and the paties of the paties or a recovery and the paties of the paties or a recovery and the paties or a recovery and the paties or a recovery and the paties of the paties of the paties or a recovery and the paties or a recovery and the paties of the pat	The patient has exper The patient has received a secukinumab for posent has had severe active and has tried and not resemaximum tolerated dosent has tried and not rese of up to 20 mg daily (or Patient has persistent elbow, knee, ankle, ar	al Special Authority approval for adalimumab or seculinenced intolerable side effects from adalimumab or seculinum and insufficient benefit from adalimumab or seculinum acriatic arthritis  The property of the provided to at least three months of oral or parenteral	mab to meet the renewal criteria for adalimumab  methotrexate at a dose of at least 20 mg weekly a dose of at least 2 g per day or leflunomide at a  at least 15 swollen, tender joints at least four joints from the following: wrist,
		or		ESR and CRP not me	ed erythrocyte sedimentation rate (ESR) greater than easured as patient is currently receiving prednisone the nore than three months	.
				and has done so lot h	ioro man unoc monuis	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:			
Reg N	lo:	First Names:	First Names:			
Name	:	Surname:	Surname:			
Addre	SS:	DOB:	Address:			
		Address:				
			Fax Number:			
	ercept - continued					
Curre Appli	ewal — psoriatic arthritis ent approval Number (if known): cations only from a rheumatologist or Practitic equisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.			
	Applicant is a rheumatologis  Applicant is a Practitioner ar  continues with etanercept tree	nd confirms that a rheumatologist has provided a lette	er, email or fax recommending that the patient			
	Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior etanercept treatment in the opinion of the treating physician					
	Etanercept to be administered at d	oses no greater than 50 mg every 7 days				
Appl	I application — pyoderma gangrenosum ications only from a dermatologist. Approvals equisites (tick boxes where appropriate)	s valid for 4 months.				
Patient has pyoderma gangrenosum*  and Patient has received three months of conventional therapy including a minimum of three pharmaceuticals (e.g. prednisone, ciclo azathioprine, or methotrexate) and not received an adequate response  A maximum of 8 doses						
Note:	Indications marked with * are unapproved in	dications.				
Curre	Renewal — pyoderma gangrenosum  Current approval Number (if known):					
	equisites(tick boxes where appropriate)					
	Patient has shown clinical improve and Patient continues to require treatm and A maximum of 8 doses					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Number	r:				Fax Number:
Etanerce	<b>pt</b> - co	ontinu	ued		
or	and and and	or	The patient has exper  The patient has receive  Patient has had rheumatoid antibody positive) for six mo  Treatment is to be used as antolerance  Patient has tried and not reserved.	arthritis (either confirmed by radiology imaging, or the nadjunct to methotrexate therapy or monotherapy we ponded to at least three months of methotrexate in cated doses unless contraindicated)	rheumatoid arthritis  e patient is cyclic citrullinated peptide (CCP)  here use of methotrexate is limited by toxicity or  maximum tolerated dose (unless contraindicated)
	and	or	dose of ciclosporin  Patient has tried and ralone or in combination	not responded to at least three months of methotrexal not responded to at least three months of therapy at the with methotrexate	he maximum tolerated dose of leflunomide
		or	Patient has persistent	symptoms of poorly controlled and active disease in ad either shoulder or hip	,

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Etanercept - continued					
Current approval Number (if known):					
Following initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically signific response to treatment in the opinion of the physician  On subsequent reapplications, the patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician					
and Etanercept to be administered at d	oses no greater than 50 mg every 7 days				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Numbe	er:				Fax Number:
Initial application — severe chronic plaque psoriasis Applications only from a dermatologist or any relevant practitioner on the recommendation of a dermatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab for severe chronic plaque psoriasis  The patient has experienced intolerable side effects from adalimumab  or  The patient has received insufficient benefit from adalimumab to meet the renewal criteria for adalimumab for severe chronic plaque psoriasis  or  Patient has "whole body" severe chronic plaque psoriasis with a Psoriasis Area and Severity Index (PASI) score of greater than 10, where lesions have been present for at least 6 months from the time of initial diagnosis  or  Patient has severe chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present for at least 6 months from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater than 10  and  Patient has tried, but had an inadequate response (see Note) to, or has experienced intolerable side effects from, at least three of the following (at maximum tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or actiretin  A PASI assessment or Dermatology Quality of Life Index (DLQI) assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment courses.					re chronic plaque psoriasis  renewal criteria for adalimumab for severe  Area and Severity Index (PASI) score of in the time of initial diagnosis  or sole of a foot, where the plaque or plaques  ere the plaques or lesions have been present ogy Life Quality Index (DLQI) score greater  ced intolerable side effects from, at least three py, methotrexate, ciclosporin, or acitretin  been completed for at least the most recent
	and		The most recent PASI or DL	QI assessment is no more than 1 month old at the tin	ne of application
Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment.					

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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PPLICANT (star	mp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
eg No:		First Names:	First Names:
ame:		Surname:	Surname:
ddress:		DOB:	Address:
		Address:	
ax Number:			Fax Number:
tanercept - c	continued		
Renewal — seve	ere chronic plaque psoriasis		
Applications from	Number (if known): n any relevant practitioner. Approv ck boxes where appropriate)		
	Following each por is sustained a or Following each por	dy" severe chronic plaque psoriasis at the start of treatment course the patient has a P at this level, when compared with the pre-treatment be corrior etanercept treatment course the patient has a D 5 or more, when compared with the pre-treatment be	ASI score which is reduced by 75% or more, aseline value ermatology Quality of Life Index (DLQI)
or	Following each pall 3 of erythema course baseline  or  Following each pall 3 of erythema course baseline	ronic plaque psoriasis of the face, or palm of a hand of corior etanercept treatment course the patient has a rea, thickness and scaling, to slight or better, or sustainvalues orior etanercept treatment course the patient has a realined at this level, as compared to the pre-treatment	eduction in the PASI symptom subscores for ed at this level, as compared to the treatment eduction of 75% or more in the skin area
or	The patient has compared to the	experienced a reduction of 75% or more in the skin as pre-treatment baseline value experienced Quality of Life Index (DLQI) improvement acing etanercept	area affected, or sustained at this level, as
	Etanercept to be administered at d	oses no greater than 50 mg every 7 days of 12 weeks of etanercept treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			np or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umbe	r:			Fax Number:
Etan	erce	pt - c	ontinued		
Appl	icatio	ns only ites(tic		als valid for 6 months.  neral spondyloarthritis* with active peripheral joint arth	nritis in at least four joints from the following:
	and		rist, elbow, knee, ankle, and eith atient has tried and not responde naximum tolerated dose	er snoulder or nip ed to at least three months of oral or parenteral metho	otrexate at a dose of at least 20 mg weekly or a
	and	Р		ed to at least three months of sulfasalazine at a dose	of at least 2 g per day (or maximum tolerated
	and and	P	atient has tried and not responde	ed to at least three months of leflunomide at a dose of	f up to 20 mg daily (or maximum tolerated dose)
		or [	Patient has a C-reactive pro	tein level greater than 15 mg/L measured no more the	an one month prior to the date of this application
		or [	Patient has an elevated ery prior to the date of this appl	throcyte sedimentation rate (ESR) greater than 25 mr ication	m per hour measured no more than one month
		[	ESR and CRP not measure done so for more than three	d as patient is currently receiving prednisone therapy months	at a dose of greater than 5 mg per day and has
Note	Indic	cations	marked with * are unapproved in	ndications.	
Rene	ewal –	– undi	fferentiated spondyloarthritis		
Appli	cation	ns only	Number (if known):from a rheumatologist or Practitik boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
		or [	Applicant is a rheumatologic	st	
	_		Applicant is a Practitioner a continues with etanercept tr	nd confirms that a rheumatologist has provided a lette eatment	er, email or fax recommending that the patient
	and	or [		itial treatment, the patient has at least a 50% decreas e to treatment in the opinion of the physician	se in active joint count from baseline and a
				t least a continuing 30% improvement in active joint c t treatment in the opinion of the treating physician	ount from baseline and a clinically significant
	and	E	tanercept to be administered at o	doses no greater than 50 mg dose every 7 days	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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PPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
eg No:				First Names:	First Names:	
e:				Surname:	Surname:	
ess:				DOB:	Address:	
				Address:		
					Fax Number:	
ximal	<b>b</b> (M	abthe	era)			
lication	ns on	ly fro	- rheumatoid arthritis - TNF m a rheumatologist or Practiti oxes where appropriate)	inhibitors contraindicated oner on the recommendation of a rheumatologist. Ap	pprovals valid for 4 months.	
[		Treat	tment with a Tumour Necrosis	s Factor alpha inhibitor is contraindicated		
and [				erosive rheumatoid arthritis (either confirmed by rad for six months duration or longer	liology imaging, or the patient is cyclic citrullinated	
and				ed to at least three months of oral or parenteral metho	otrovato at a doco of at loagt 20 mg wookly or a	
and	ш		imum tolerated dose	gu to at least tillee months of oral of paremeral metho	offexale at a dose of at least 20 mg weekly of a	
Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with sulfasalazine and hydroxychloroquine sulphate (at maximum tolerated doses)				otrexate in combination with sulfasalazine and		
and	Patient has tried and not responded to at least three months of oral or parenteral methotrexate in combination with the m					
	tolerated dose of ciclosporir				i methotiexate in combination with the maximum	
			Patient has tried and not res	sponded to at least three months of oral or parenteral methotrexate in combination with intramuscular		
	or		Patient has tried and not res	sponded to at least three months of therapy at the ma renteral methotrexate	aximum tolerated dose of leflunomide alone or in	
and						
	or		Patient has persistent symp	toms of poorly controlled and active disease in at lea	st 20 swollen, tender joints	
	01		Patient has persistent symp knee, ankle, and either shou	toms of poorly controlled and active disease in at lea ulder or hip	ast four joints from the following: wrist, elbow,	
and						
	or		Patient has a C-reactive pro	otein level greater than 15 mg/L measured no more th	nan one month prior to the date of this application	
				t measured as patient is currently receiving prednisor ore than three months	ne therapy at a dose of greater than 5 mg per	
and			Rituximab to be used as an	adjunct to methotrexate or leflunomide therapy		
	or		Patient is contraindicated to	both methotrexate and leflunomide, requiring rituxim	nab monotherapy to be used	
1						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:	
Name:				Surname:	Surname:	
Addres	s:			DOB:	Address:	
				Address:		
Fax Nu	ımber	r:			Fax Number:	
Rituxi	imal	<b>b</b> (Mabthe	era) - continued			
Applic	ation	s only fror	- rheumatoid arthritis - prio m a rheumatologist or Practitio oxes where appropriate)	r TNF inhibitor use oner on the recommendation of a rheumatologist. Ap	provals valid for 4 months.	
		and	The patient has had an initial rheumatoid arthritis	al community Special Authority approval for at least or	ne of etanercept and/or adalimumab for	
		or		erienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept		
				ur month trial of adalimumab and/or etanercept, the paranercept for rheumatoid arthritis	patient did not meet the renewal criteria for	
	and					
			Rituximab to be used as an	adjunct to methotrexate or leflunomide therapy		
		or _	Patient is contraindicated to	both methotrexate and leflunomide, requiring rituxima	ab monotherapy to be used	
	and [	Maxi	mum of two 1,000 mg infusion	ns of rituximab given two weeks apart		
Renev	wal –	– rheuma	toid arthritis - re-treatment	in 'partial responders' to rituximab		
			mber (if known):			
		-	n a rheumatologist or Practition (in a rheumatologi	oner on the recommendation of a rheumatologist. Ap	provals valid for 4 months.	
	1	or		itial course of rituximab infusions the patient had betw linically significant response to treatment in the opinic		
		or		econd course of rituximab infusions the patient had at nificant response to treatment in the opinion of the ph		
				ird and subsequent courses of rituximab infusions, th joint count from baseline and a clinically significant re		
	and [ and	Ritux	imab re-treatment not to be g	iven within 6 months of the previous course of treatm	ent	
		or	Rituximab to be used as an	adjunct to methotrexate or leflunomide therapy		
			Patient is contraindicated to	both methotrexate and leflunomide, requiring rituxima	ab monotherapy to be used	
	and  Maximum of two 1,000 mg infusions of rituximab given two weeks apart					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Rituximab (Mabthera) - continued					
Prerequisites(tick boxes where appropriate)  At 4 months following the init baseline and a clinically sign or  At 4 months following the set 30% improvement in active juphysician  and  Rituximab re-treatment not to be gi	tial course of rituximab infusions the patient had at le ificant response to treatment in the opinion of the photon and subsequent courses of rituximab infusions oint count from baseline and a clinically significant reven within 6 months of the previous course of treatment in the opinion of the photon and subsequent courses of rituximab infusions oint count from baseline and a clinically significant reven within 6 months of the previous course of treatment of the previous course of the previous course of treatment of the previous course of the previo	east a 50% decrease in active joint count from ysician the patient demonstrates at least a continuing sponse to treatment in the opinion of the			
Patient is contraindicated to	both methotrexate and leflunomide, requiring rituxima	ab monotherapy to be used			
and Maximum of two 1,000 mg infusions of rituximab given two weeks apart					

#### SA2157 - Adalimumab (Humira - Alternative brand)

Arthritis - polyarticular course juvenile idiopathic - Initial application	
Arthritis - polyarticular course juvenile idiopathic - Renewal	
Arthritis - psoriatic - Initial application	
Arthritis - psoriatic - Renewal	
Arthritis – oligoarticular course juvenile idiopathic - Initial application	244
Arthritis – oligoarticular course juvenile idiopathic - Renewal	244
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# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Reg N	0:	First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Adali	mumab (Humira - Alternative brar	nd)		
Appl	I application — Behcet's disease – severe ications from any relevant practitioner. Approequisites(tick boxes where appropriate)	vals valid for 6 months.		
		intolerable side effects from adalimumab (Amgevita)	o following a minimum of 4 weeks treatment	
	Patient has developed symp (Amgevita) and clinician attri	toms of loss of disease control following a minimum obutes this loss of disease response to a change in tre	of 4 weeks treatment with adalimumab eatment regimen	
	and Patient has received a maximum o	f 6 months treatment with Amgevita		
	and	al Authority approval for the Humira brand of adalimu	umah for this indication	
	and			
	Adailmumab to be administered at	doses no greater than 40 mg every 14 days		
Rene	ewal — Behcet's disease – severe			
Curre	ent approval Number (if known):			
	cations from any relevant practitioner. Approv			
Prere	equisites(tick boxes where appropriate)			
		I response to treatment with measurably improved qu	uality of life	
	Adalimumab to be administered at	doses no greater than 40 mg every 14 days		
- 1				
Appl	I application — Hidradenitis suppurativa ications only from a dermatologist or Practitio equisites(tick boxes where appropriate)	ner on the recommendation of a dermatologist. Appr	rovals valid for 6 months.	
	The patient has experienced	intolerable side effects from adalimumab (Amgevita)	following a minimum of 4 weeks treatment	
	Patient has developed symp	toms of loss of disease control following a minimum of butes this loss of disease response to a change in tre		
	and Patient has received a maximum o	f 6 months treatment with Amgevita		
	and	al Authority approval for the Humira brand of adalimu	umab for this indication	
	and	doses no greater than 40 mg every 7 days. Fortnigh		
		3 · · , · · · · · · · · · · · · · · · ·	, ,	

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Reg No:	First Names:	First Names:				
Name:	Surname:	Surname:				
Address:	DOB:	Address:				
	Address:					
Fax Number:		Fax Number:				
Adalimumab (Humira - Alternative brar	nd) - continued					
Renewal — Hidradenitis suppurativa						
Current approval Number (if known):						
Initial application — Psoriasis - severe chronic plaque Applications only from a dermatologist or Practitioner on the recommendation of a dermatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)						
or Patient has developed symp	intolerable side effects from adalimumab (Amgevita) toms of loss of disease control following a minimum of butes this loss of disease response to a change in tro	of 4 weeks treatment with adalimumab				
and Patient has previously had a Speci	f 6 months treatment with Amgevita al Authority approval for the Humira brand of adalimu	umab for this indication				
Adalimumab to be administered at	doses no greater than 40 mg every 14 days					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)				sticker acceptable)	PATIENT NHI:	. REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:					Surname:	Surname:	
Addre	ess:				DOB:	Address:	
					Address:		
Fax N	lumbe	r:				Fax Number:	
Adal	imur	nab	(Hun	nira - Alternative braı	nd) - continued		
Rene	ewal -	– Pso	oriasis	s - severe chronic plaque			
Appli	icatior	ns onl	y from	ber (if known):a dermatologist or Practition (ses where appropriate)	ner on the recommendation of a dermatologist. Appro	ovals valid for 6 months.	
			and	_	dy" severe chronic plaque psoriasis at the start of tre	atment	
	Following each more, or is sus			or Following each more, or is sust	prior adalimumab treatment course the patient has a ained at this level, when compared with the pre-adalin prior adalimumab treatment course the patient has a 5 or more, when compared with the pre-treatment bases.	mumab treatment baseline value  Dermatology Quality of Life Index (DLQI)	
	a	and	_	ronic plaque psoriasis of the face, or palm of a hand	or sole of a foot at the start of treatment		
				Following each for all 3 of eryth treatment cours  Following each	prior adalimumab treatment course the patient has a nema, thickness and scaling, to slight or better, or sus se baseline values prior adalimumab treatment course the patient has a tained at this level, as compared to the pre-adalimum	reduction of 75% or more in the skin area	
	and		Adalim	numab to be administered at	doses no greater than 40 mg every 14 days		
App	licatio	ns on	ly from	Pyoderma gangrenosum n a dermatologist. Approvals kes where appropriate)	s valid for 6 months.		
					d intolerable side effects from adalimumab (Amgevita)	) following a minimum of 4 weeks treatment	
					ptoms of loss of disease control following a minimum of 4 weeks treatment with adalimumab tributes this loss of disease response to a change in treatment regimen		
	and		Patien	t has received a maximum o	of 6 months treatment with Amgevita		
	and and		Patien	t has previously had a Spec	ial Authority approval for the Humira brand of adalimu	umab for this indication	
	A maximum of 8 doses						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:				
Adalimumab (Humira - Alternative bra	nd) - continued					
Renewal — Pyoderma gangrenosum						
Current approval Number (if known):						
Applications only from a dermatologist. Approval						
Prerequisites(tick boxes where appropriate)						
· · ·	nical improvement and continues to require treatment					
and A maximum of 8 doses						
Initial application — Crohn's disease - adult Applications only from a gastroenterologist or Pr	actitioner on the recommendation of a gastroenterolog	ist Approvals valid for 6 months				
Prerequisites(tick boxes where appropriate)		ion representation of months.				
and a maximum of 6 month	d intolerable side effects from adalimumab (Amgevita is treatment with Amgevitat	) following a minimum of 4 weeks treatment,				
	ptoms of loss of disease control following a minimum					
6 months treatment with Ar	ngevita and clinician attributes this loss of disease res	ponse to a change in treatment regimen				
Patient has Crohn's and is	considered to be at risk of disease destabilisation if th	ere were to be a change to current treatment				
and Patient has previously had a Spe	cial Authority approval for the Humira brand of adalim	umab for this indication				
and						
Adailmumab to be administered a	tt doses no greater than 40 mg every 14 days					
Renewal — Crohn's disease - adult						
Current approval Number (if known):						
Prerequisites(tick boxes where appropriate)						
CDAL access has varioused by	, 100 points from the CDAL scare when the potient was	o initiated an adalimumah				
or	100 points from the CDAI score when the patient wa	s initiated on adalimumab				
or CDAI score is 150 or less						
The patient has demonstra	ted an adequate response to treatment, but CDAI sco	re cannot be assessed				
and Adalimumab to be administered a	at doses no greater than 40 mg every 14 days					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:				
Adalimumab (Humira - Alternative brai	nd) - continued					
Initial application — Crohn's disease - children Applications only from a gastroenterologist or Pra Prerequisites(tick boxes where appropriate)	ctitioner on the recommendation of a gastroenterolog	ist. Approvals valid for 6 months.				
or and a maximum of 6 months  Patient has developed symp 6 months treatment with Am  or	d intolerable side effects from adalimumab (Amgevita treatment with Amgevita streatment with Amgevita streatment with Amgevita streatment with Amgevita and clinician attributes this loss of disease resonsidered to be at risk of disease destabilisation if the	of 4 weeks treatment, and a maximum of ponse to a change in treatment regimen				
and Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimed doses no greater than 40 mg every 14 days					
Renewal — Crohn's disease - children						
Current approval Number (if known):Applications only from a gastroenterologist or Prace  Prerequisites(tick boxes where appropriate)	titioner on the recommendation of a gastroenterologi	st. Approvals valid for 6 months.				
PCDAI score has reduced b	y 10 points from the PCDAI score when the patient w	ras initiated on adalimumab				
PCDAI score is 15 or less						
	ed an adequate response to treatment, but PCDAI sc	ore cannot be assessed				
Adalimumab to be administered at	doses no greater than 40 mg every 14 days					
Initial application — Crohn's disease - fistulising Applications only from a gastroenterologist or Practitioner on the recommendation of a gastroenterologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)						
and a maximum of 6 months	d intolerable side effects from adalimumab (Amgevita s treatment with Amgevita	) following a minimum of 4 weeks treatment,				
6 months treatment with Am	otoms of loss of disease control following a minimum gevita and clinician attributes this loss of disease res					
Patient has Crohn's and is c	onsidered to be at risk of disease destabilisation if th	ere were to be a change to current treatment				
and Patient has previously had a Spec	ial Authority approval for the Humira brand of adalim	umab for this indication				
	doses no greater than 40 mg every 14 days					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Adalimumab (Humira - Alternative brar	nd) - continued		
Renewal — Crohn's disease - fistulising			
Current approval Number (if known):			
, ,	titioner on the recommendation of a gastroenterologi	st. Approvals valid for 6 months.	
Prerequisites(tick boxes where appropriate)	g.		
The number of open draining fistulae have decreased from baseline by at least 50%  or  There has been a marked reduction in drainage of all fistula(e) from baseline as demonstrated by a reduction in the Fistula Assessment score, together with less induration and patient-reported pain			
			and
Adalimumab to be administered at	doses no greater than 40 mg every 14 days		
Initial application — Ocular inflammation – chroapplications from any relevant practitioner. Appro			
Prerequisites(tick boxes where appropriate)			
and a maximum of 6 months	I intolerable side effects from adalimumab (Amgevita)	following a minimum of 4 weeks treatment,	
or	toms of loss of disease control following a minimum o	of 4 weeks treatment with Amgevita, and a	
	ment with Amgevita and clinician attributes this loss o		
or	nsidered to be at risk of vision loss if they were to cha	ange treatment	
and			
and Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimu	imab for this indication	
Adalimumab to be administered at	doses no greater than 40 mg every 14 days		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Adalimumab (Humira - Alternative brai	nd) - continued		
Renewal — Ocular inflammation – chronic			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx			
Prerequisites(tick boxes where appropriate)			
The patient has had a good clinical response following 12 weeks' initial treatment    The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a good clinical response following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has had a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has a sustained reduction in inflammation (Standardisation of Uve Nomence Following 12 weeks' initial treatment   The patient has a sustained steroid sparing effect, allowing reduction in			
and a maximum of 6 months	· ·		
maximum of 6 months treati regimen or	ntoms of loss of disease control following a minimum of ment with Amgevita and clinician attributes this loss c	of disease response to a change in treatment	
	nsidered to be at risk of vision loss if they were to cha	ange treatment	
and Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimu	umab for this indication	
Adalimumab to be administered at doses no greater than 40 mg every 14 days			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Adalimumab (Humira - Alternative brar	d) - continued	
Renewal — Ocular inflammation – severe		
Current approval Number (if known):		
Applications from any relevant practitioner. Approv		
or Following each 12-month tre Nomenclature (SUN) criteria of uveitic cystoid macular oe or Following each 12-month tre < 10mg daily, or steroid drop and	clinical response following 3 initial doses  atment period, the patient has had a sustained reduce  < ½+ anterior chamber or vitreous cells, absence of dema)  atment period, the patient has a sustained steroid sp is less than twice daily if under 18 years old  doses no greater than 40 mg every 14 days	active vitreous or retinal lesions, or resolution
Initial application — ankylosing spondylitis Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
or	intolerable side effects from adalimumab (Amgevita) toms of loss of disease control following a minimum of	-
and Patient has received a maximum o	f 6 months treatment with Amgevita	
Patient has previously had a Speci	al Authority approval for the Humira brand of adalimu	ımab for this indication
	doses no greater than 40 mg every 14 days	
Renewal — ankylosing spondylitis		
Current approval Number (if known):	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
improvement in BASDAI of 50%, w	vement in BASDAI of 4 or more points from pre-trea hichever is less	tment baseline on a 10 point scale, or an
Adalimumab to be administered at	doses no greater than 40 mg every 14 days	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Adalimumab (Humira - Alternative bra			
Initial application — Arthritis – oligoarticular c	<u> </u>	named specialist or rheumatologist. Approvals	
The patient has experienced	d intolerable side effects from adalimumab (Amgevita)	) following a minimum of 4 weeks treatment	
Patient has developed symp	otoms of loss of disease control following a minimum of ibutes this loss of disease response to a change in tre		
and	of 6 months treatment with Amgevita ial Authority approval for the Humira brand of adalimu	ımab for this indication	
valid for 6 months.  Prerequisites(tick box where appropriate)	•		
Initial application — Arthritis - polyarticular co Applications only from a named specialist, rheum valid for 6 months. Prerequisites(tick boxes where appropriate)	urse juvenile idiopathic atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals	
or	d intolerable side effects from adalimumab (Amgevita)	-	
and Patient has received a maximum of	ibutes this loss of disease response to a change in tree of 6 months treatment with Amgevita ial Authority approval for the Humira brand of adalimutes.		
Renewal — Arthritis - polyarticular course juvenile idiopathic			
valid for 6 months.  Prerequisites(tick box where appropriate)  The patient demonstrates at least a cont	atologist or Practitioner on the recommendation of a n		
assessment from baseline			

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APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
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Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brai	nd) - continued	
Initial application — Arthritis - psoriatic Applications only from a named specialist, rheums valid for 6 months.  Prerequisites(tick boxes where appropriate)	atologist or Practitioner on the recommendation of a r	named specialist or rheumatologist. Approvals
or	d intolerable side effects from adalimumab (Amgevita)	
	ibutes this loss of disease response to a change in tre	
Patient has received a maximum c	of 6 months treatment with Amgevita	
Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimu	umab for this indication
Adalimumab to be administered at	doses no greater than 40 mg every 14 days	
L		
Renewal — Arthritis - psoriatic		
Current approval Number (if known):		
Applications only from a named specialist, rheuma valid for 6 months.  Prerequisites(tick boxes where appropriate)	tologist or Practitioner on the recommendation of a n	amed specialist or rheumatologist. Approvals
to prior adalimumab treatment in the	a continuing 30% improvement in active joint count fr ne opinion of the treating physician	om baseline and a clinically significant response
Adalimumab to be administered at	doses no greater than 40 mg every 14 days	
Initial application — Arthritis – rheumatoid Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	ioner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced or	d intolerable side effects from adalimumab (Amgevita)	) following a minimum of 4 weeks treatment
Patient has developed symp	otoms of loss of disease control following a minimum of ibutes this loss of disease response to a change in tre	
	of 6 months treatment with Amgevita	
Patient has previously had a Spec	ial Authority approval for the Humira brand of adalimu	umab for this indication
	ered at doses no greater than 40 mg every 14 days	
	itant methotrexate and requires doses of adalimumab	higher than 40 mg every 14 days to maintain

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Adalimumab (Humira - Alternative brar	nd) - continued	
Renewal — Arthritis – rheumatoid		
Current approval Number (if known):  Applications only from a rheumatologist or Practition  Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
The patient demonstrates at least to prior adalimumab treatment in the	a continuing 30% improvement in active joint count fr ne opinion of the treating physician	om baseline and a clinically significant response
or	ered at doses no greater than 40 mg every 14 days stant methotrexate and requires doses of adalimumab	higher than 40 mg every 14 days to maintain
Initial application — Still's disease – adult-onse Applications only from a rheumatologist or Practiti Prerequisites(tick boxes where appropriate)	et (AOSD) oner on the recommendation of a rheumatologist. Ap	oprovals valid for 6 months.
The patient has experienced	I intolerable side effects from adalimumab (Amgevita)	following a minimum of 4 weeks treatment
	toms of loss of disease control following a minimum of ibutes this loss of disease response to a change in tro	
and Patient has received a maximum c	of 6 months treatment with Amgevita	
Patient has previously had a Speci	ial Authority approval for the Humira brand of adalimu	mab for this indication
Renewal — Still's disease – adult-onset (AOSD	)	
Current approval Number (if known):		
Applications only from a rheumatologist or Practition <b>Prerequisites</b> (tick box where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.
The patient has demonstrated a sustained	ed improvement in inflammatory markers and function	al status

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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	r:		Fax Number:
Omalizun	nab		
Application	Patient must be aged 6 years or old Patient has a diagnosis of severe a Past or current evidence of atopy, of Total serum human immunoglobulis Proven adherence with optimal inh propionate 1,000 mcg per day or e		oid (budesonide 1,600 mcg per day or fluticasone
or contraindicated or not tolera		s of systemic corticosteroids equivalent to at least 28 ed acerbations needing systemic corticosteroids in the pd use of oral corticosteroids for at least 3 days or par	previous 12 months, where an exacerbation is
and  Patient has an Asthma Control Test (ACT) score of 10 or less  and  Baseline measurements of the patient's asthma control using the ACT and oral corticosteroid dose must be made at the time application, and again at around 26 weeks after the first dose to assess response to treatment			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPL	PPLICANT (stamp or sticker acceptable) PATIENT NHI:			REFERRER Reg No:		
Reg N	eg No: First Names: First Names: First Names:			First Names:		
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
						Fax Number:
Oma	izun	nab	- cor	ntinued		
Appli	cation	s onl	y fror	severe chronic spontaneon a clinical immunologist or coxes where appropriate)	ous urticaria lermatologist. Approvals valid for 6 months.	
	and		Patie	nt must be aged 12 years or	older	
	Patient is symptomatic		d Patient has a Dermat	c with Urticaria Activity Score 7 (UAS7) of 20 or above clogy life quality index (DLQI) of 10 or greater rol Test (UCT) of 8 or less	9	
Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and ciclosporin (> 3 mg/kg day) for a 6 weeks  Patient has been taking high dose antihistamines (e.g. 4 times standard dose) and at least 3 courses of systemic cor (> 20 mg prednisone per day for at least 5 days) in the previous 6 months						
		or		Patient has developed signi	ficant adverse effects whilst on corticosteroids or ciclo	osporin
	and					
				Treatment to be stopped if i	nadequate response* following 4 doses	
	Complete response* to 6 doses of omalizumab					
				sthma		
				nber (if known):		
				n a clinical immunologist or r exes where appropriate)	espiratory specialist. Approvals valid for 2 years.	
	and_		An in	crease in the Asthma Contro	l Test (ACT) score of at least 5 from baseline	
	[		A red	uction in the maintenance or	al corticosteroid dose or number of exacerbations of a	at least 50% from baseline

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Omalizumab - continued			
Renewal — severe chronic spontaneous urtica	ria		
Current approval Number (if known):			
Applications only from a clinical immunologist or d	ermatologist. Approvals valid for 6 months.		
Prerequisites(tick boxes where appropriate)			
Patient has previously adequately responded* to 6 doses of omalizumab			
Patient has previously had a	complete response* to 6 doses of omalizumab		
Patient has relapsed after co	essation of omalizumab therapy		

Note: \*Inadequate response defined as less than 50% reduction in baseline UAS7 and DLQI score, or an increase in Urticaria Control Test (UCT) score of less than 4 from baseline. Patient is to be reassessed for response after 4 doses of omalizumab. Complete response is defined as UAS7 less than or equal to 6 and DLQI less than or equal to 5; or UCT of 16. Relapse of chronic urticaria on stopping prednisone/ciclosporin does not justify the funding of omalizumab.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 250 **Form SA1596** 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:	
Siltuximab			
and Treatment with an adequate trial of and	ologist. Approvals valid for 6 months.  e idiopathic multicentric Castleman's Disease  corticosteroids has proven ineffective  doses no greater than 11 mg/kg every 3 weeks		
Renewal			
Current approval Number (if known):			
Applications only from a haematologist or rheumat <b>Prerequisites</b> (tick box where appropriate)	ologist. Approvals valid for 12 months.		
The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		cceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umbe	er:			Fax Number:
Pertu	ızun	nab			
Appli	cation	sites(tick boxes where	ractitioner. Approvappropriate)	vals valid for 12 months.  cancer expressing HER-2 IHC 3+ or ISH+ (including	FISH or other current technology)
	Patient is chemotherapy tro				a treatment free interval of at least 12 months
and  The patient has good performance status (ECOG grade 0-1)  and  Pertuzumab to be administered in combination with trastuzumab  and  Pertuzumab maximum first dose of 840 mg, followed by maximum of 420 mg every 3 weeks  and  Pertuzumab to be discontinued at disease progression			veeks		
Rene	- lewe	— metastatic breast	cancer		
Curre	ent ap	oproval Number (if kno	own):	vals valid for 12 months.	
		and		reast cancer expressing HER-2 IHC 3+ or ISH+ (incl	
	or		us previously disco rogression	ntinued treatment with pertuzumab and trastuzumab	for reasons other than severe toxicity or
			s signs of disease	progression	
			as not progressed	during previous treatment with pertuzumab and tras	tuzumab
	1				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:		
Obinutuzumab				
and The patient is obinutuzumab treatr and The patient is not eligible for full do reduced renal function (creatinine and Patient has adequate neutrophil ar and Patient has good performance state and	stage A, B or C CD20+ chronic lymphocytic leukaem ment naive use FCR due to comorbidities with a score > 6 on the clearance < 70mL/min) und platelet counts* unless the cytopenias are a conse	e Cumulative Illness Rating Scale (CIRS) or quence of marrow infiltration by CLL		
Note: Chronic lymphocytic leukaemia includes smillness/impairment in the patient. 'Good performar symptoms a higher ECOG (2 or 3) is acceptable w	Obinutuzumab to be administered at a maximum cumulative dose of 8,000 mg and in combination with chlorambucil for a maximum of 6 cycles  Note: Chronic lymphocytic leukaemia includes small lymphocytic lymphoma. Comorbidity refers only to illness/impairment other than CLL induced illness/impairment in the patient. 'Good performance status' means ECOG score of 0-1, however, in patients temporarily debilitated by their CLL disease symptoms a higher ECOG (2 or 3) is acceptable where treatment with obinutuzumab is expected to improve symptoms and improve ECOG score to < 2.  * Neutrophil greater than or equal to 1.5 × 10 <sup>9</sup> /L and platelets greater than or equal to 75 × 10 <sup>9</sup> /L.			
Initial application — follicular / marginal zone In Applications only from a relevant specialist or med Prerequisites (tick boxes where appropriate)	ymphoma ical practitioner on the recommendation of a relevant	specialist. Approvals valid for 9 months.		
Patient has follicular lympho or Patient has marginal zone ly				
Patient is refractory to or has relap	sed within 12 months of a rituximab containing comb	ined chemo-immunotherapy regimen*		
Patient has been previously treate	d with no more than four chemotherapy regimens			
and Obinutuzumab to be administered	at a maximum dose of 1000 mg for a maximum of 6	cycles in combination with chemotherapy*		
Note: * includes unapproved indications	Note: * includes unapproved indications			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Obinutuzumab - continued					
Renewal — follicular / marginal zone lymphoma	1				
Current approval Number (if known):					
Applications only from a relevant specialist or medi <b>Prerequisites</b> (tick boxes where appropriate)	cal practitioner on the recommendation of a relevant	specialist. Approvals valid for 24 months.			
Patient has no evidence of disease	progression following obinutuzumab induction thera	ру			
	Obinutuzumab to be administered at a maximum of 1000 mg every 2 months for a maximum of 2 years				
Obinutuzumab to be discontinued at disease progression					

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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 more Prerequisites (tick boxes where appropriate)  Patient has locally advanced, non-metastatic, squamous cell cancer of the head and neck  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					
Prerequisites(tick boxes where appropriate)	relevant practitioner on the recommendation of a rele relevant practitioner on the recommendation of a rele rancer located on the left side of the colon (see Note)	evant specialist. Approvals valid for 6 months.			
and	g disease is RAS and BRAF wild-type				
Patient has an ECOG performance	e score of 0-2				
Patient has not received prior fund	led treatment with cetuximab				
	combination with chemotherapy				
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					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			np o	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name:					Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbei	r:				Fax Number:
Aflib	erce	pt				
Appli	ication	s only	fron	wet age related macular den an ophthalmologist. Approvinces where appropriate)		
	or	and and or	or or	Polypoidal choroidal v Choroidal neovascular The patient has develor There is worsening of apart There is no structural damage Patient has not previously be Patient has current approval 3 months	lar degeneration (wet AMD) asculopathy r membrane from causes other than wet AMD oped severe endophthalmitis or severe posterior uveit vision or failure of retina to dry despite three intraocu ge to the central fovea of the treated eye een treated with ranibizumab for longer than 3 months to use ranibizumab for treatment of wAMD and was fore June 2018) received treatment with ranibizumab	lar injections of bevacizumab four weeks
Appli	ication	is only	from k bo	diabetic macular oedema n an ophthalmologist. Approv xes where appropriate)		
Patient has centre involving diabetic macular oedema (DM and Patient's disease is non responsive to 4 doses of intravitre and				· ·	,	
					-	
	and	F 	atier	nt has reduced visual acuity b	petween 6/9 – 6/36 with functional awareness of redu	ction in vision
	and	F	atier	nt has DMO within central OC	CT (ocular coherence tomography) subfield > 350 mic	rometers
	[	T	here	is no centre-involving sub-re	tinal fibrosis or foveal atrophy	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:				
Aflibercept - continued						
Renewal — wet age related macular deg	eneration					
Current approval Number (if known):						
Applications only from an ophthalmologist. <b>Prerequisites</b> (tick boxes where appropriate						
Documented benefit must be demonstrated to continue  and Patient's vision is 6/36 or better on the Snellen visual acuity score  and There is no structural damage to the central fovea of the treated eye						
Renewal — diabetic macular oedema						
Current approval Number (if known):						
Applications only from an ophthalmologist. <b>Prerequisites</b> (tick boxes where appropriate						
There is stability or two lines	s of Snellen visual acuity gain					
There is structural improver	nent on OCT scan (with reduction in intra-retinal cysts, ce	entral retinal thickness, and sub-retinal fluid)				
Patient's vision is 6/36 or be	etter on the Snellen visual acuity score					
	sub-retinal fibrosis or foveal atrophy					
	months treatment with (2nd line anti-VEGF agent), patien sponse	t has retrialled with at least one injection of				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:		
Secukinumab				
Initial application — severe chronic plaque ps Applications only from a dermatologist or any rele Prerequisites(tick boxes where appropriate)	oriasis – second-line biologic evant practitioner on the recommendation of a dermate	ologist. Approvals valid for 4 months.		
The patient has had an initial Spe for severe chronic plaque psorias and	cial Authority approval for adalimumab or etanercept, is	or has trialled infliximab in a Health NZ Hospital,		
The patient has experience	ienced intolerable side effects from adalimumab, etanercept or infliximab			
and The patient has received in	sufficient benefit from adalimumab, etanercept or infli	ximab		
A Psoriasis Area and Severity Inc	lex (PASI) assessment or Dermatology Quality of Life reatment course, preferably while still on treatment but			
and	sessment is no more than 1 month old at the time of	application		
Initial application — severe chronic plaque ps Applications only from a dermatologist or any rele Prerequisites(tick boxes where appropriate)	oriasis – first-line biologic evant practitioner on the recommendation of a dermate	ologist. Approvals valid for 4 months.		
10, where lesions have bee	evere chronic plaque psoriasis with a Psoriasis Area and present for at least 6 months from the time of initial			
	plaque psoriasis of the face, or palm of a hand or sole months from the time of initial diagnosis	e of a foot, where the plaque or plaques have		
Patient has severe chronic	localised genital or flexural plaque psoriasis where the e of initial diagnosis, and with a Dermatology Life Qua			
	equate response (see Note) to, or has experienced in loses unless contraindicated): phototherapy, methotre			
	gy Quality of Life Index (DLQI) assessment has been a still on treatment but no longer than 1 month following			
	sessment is no more than 1 month old at the time of	application		
psoriasis, a PASI score of greater than 10, as ass recent prior treatment; for severe chronic plaque p for erythema, thickness and scaling are rated as	m of 12 weeks of treatment. "Inadequate response" is sessed preferably while still on treatment but no longe osoriasis of the face, hand. foot, genital or flexural are severe or very severe, and for the face, palm of a han as assessed preferably while still on treatment but no	r than 1 month following cessation of the most eas, at least 2 of the 3 PASI symptom sub scores d or sole of a foot the skin area affected is 30% or		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			np or	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:					Surname:	Surname:	
Addres	ss:				DOB:	Address:	
					Address:		
Fax N	umbe	r:				Fax Number:	
Secu	kinu	ımab	- coi	ntinued			
Rene	wal –	– seve	ere ch	nronic plaque psoriasis –	first and second-line biologic		
		•		ber (if known):			
			-	relevant practitioner. Approtes where appropriate)	vals valid for 6 months.		
[							
					nas reduced by 75% or more (PASI 75) as compared	to baseline PASI prior to commencing	
			or	secukinumab			
				commencing secuking	ology Quality of Life Index (DLQI) improvement of 5 ournab	r more, as compared to baseline DLQI prior to	
		or		_			
			and		ronic localised genital or flexural plaque psoriasis at t	he start of treatment	
			unu		experienced a reduction of 75% or more in the skin a	area affected, or sustained at this level, as	
				compared to the	e pre-treatment baseline value		
					ermatology Quality of Life Index (DLQI) improvement of 5 or more, as compared to baseline DLQI		
				P			
	and	s	Secuk	inumab to be administered a	at a maximum dose of 300 mg monthly		
Initia	Lann	licatio	n	ankylosing spondylitis – s	acond-line higheric		
Appli	cation	is only	from	a rheumatologist or Practiti	oner on the recommendation of a rheumatologist. Ap	provals valid for 3 months.	
Prere	equisi	ites(tic	ck box	es where appropriate)			
	and	П Т	he pa	atient has had an initial Spec	cial Authority approval for adalimumab and/or etanero	ept for ankylosing spondylitis	
	anu			The patient has experienced	d intolerable side effects from a reasonable trial of ada	alimumab and/or etanercept	
		or		Following 12 weeks of adali	mumab and/or etanercept treatment, the patient did r	not meet the renewal criteria for adalimumab	
				and/or etanercept for ankylo		ist most the follower shorter of dealimination	
				ng spondylitis – second-li	•		
				ber (if known):a rheumatologist or medica	I practitioner on the recommendation of a rheumatolo	gist. Approvals valid for 6 months.	
		-		es where appropriate)		gioti i pproteio talla loi o montio.	
			ollow	ing 12 weeks initial treatme	nt of secukinumab treatment, BASDAI has improved	by 4 or more points from pre-secukinumab	
	and			ne on a 10 point scale, or by		s, . s. more pointe nom pre decommentab	
	إ	F	hysic	ian considers that the patie	nt has benefitted from treatment and that continued tr	eatment is appropriate	
	and		Secuk	inumab to be administered a	at doses no greater than 300 mg monthly		
L							

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			пр о	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:					Surname:	Surname:	
Addre	ess:				DOB:	Address:	
					Address:		
Fax Number:						Fax Number:	
Initia Appl	al application	lications only	n — fron	psoriatic arthritis n a rheumatologist. Approva	ls valid for 6 months.		
		and		Patient has had an initial Sp	pecial Authority approval for adalimumab, etanercept of	or infliximab for psoriatic arthritis	
		unu		Patient has experience	ed intolerable side effects from adalimumab, etanero	ept or infliximab	
			or		insufficient benefit from adalimumab, etanercept or inf ept or infliximab for psoriatic arthritis	fliximab to meet the renewal criteria for	
Patient has had severe active psoriatic arthritis for six month and  Patient has tried and not responded to at least three months or a maximum tolerated dose  Patient has tried and not responded to at least three months dose of up to 20 mg daily (or maximum tolerated doses)  Patient has persistent symptoms of poorly controlled elbow, knee, ankle, and either shoulder or hip  Patient has a C-reactive protein level greater than 15 application  Patient has an elevated erythrocyte sedimentation ration or ESR and CRP not measured as patient is currently reand has done so for more than three months		sponded to at least three months of oral or parenteral see sponded to at least three months of sulfasalazine at a or maximum tolerated doses) It symptoms of poorly controlled and active disease in at symptoms of poorly controlled and active disease in and either shoulder or hip  ive protein level greater than 15 mg/L measured no med erythrocyte sedimentation rate (ESR) greater than assured as patient is currently receiving prednisone the	dose of at least 2 g per day or leflunomide at a at least 15 swollen, tender joints at least four joints from the following: wrist, hore than one month prior to the date of this 25 mm per hour				
Curr	ent ap	proval	Nun	c arthritis nber (if known):			
		-		n a rheumatologist or Practiti exes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
					itial treatment, the patient has at least a 50% decreas se to treatment in the opinion of the physician	e in active joint count from baseline and a	
					t least a continuing 30% improvement in active joint conab treatment in the opinion of the treating physician	ount from baseline and a clinically significant	
	and Secukinumab to be administered			kinumab to be administered	at doses no greater than 300 mg monthly		

### SA2487 - Infliximab

	004
Crohn's disease (adults) - Initial application	261
Crohn's disease (adults) - Renewal	
Crohn's disease (children) - Initial application	
Crohn's disease (children) - Renewal	
Graft vs host disease - Initial application	
Pulmonary sarcoidosis - Initial application	
Acute fulminant ulcerative colitis - Initial application	
Ankylosing spondylitis - Initial application	263
Ankylosing spondylitis - Renewal	
Chronic ocular inflammation - Initial application	
Chronic ocular inflammation - Renewal	264
Fistulising Crohn's disease - Initial application	265
Fistulising Crohn's disease - Renewal	265
Fulminant ulcerative colitis - Renewal	
Immune checkpoint inhibitor toxicity in malignancy* - Initial application	275
Immune checkpoint inhibitor toxicity in malignancy* - Renewal	
Inflammatory bowel arthritis – axial - Initial application	
Inflammatory bowel arthritis – axial - Renewal	
Inflammatory bowel arthritis – peripheral - Initial application	
Inflammatory bowel arthritis – peripheral - Renewal	
Neurosarcoidosis - Initial application	
Neurosarcoidosis - Renewal	
Plague psoriasis - Initial application	
Plaque psoriasis - Renewal	
Previous use - Initial application	
Psoriatic arthritis - Initial application	
Psoriatic arthritis - Renewal	
Pyoderma gangrenosum - Initial application	
Pyoderma gangrenosum - Renewal	
Rheumatoid arthritis - Initial application	
Rheumatoid arthritis - Renewal	270
Severe Behcet's disease - Initial application	
Severe Behcet's disease - Renewal	
Severe ocular inflammation - Initial application	
Severe ocular inflammation - Initial application  Severe ocular inflammation - Renewal	
Ulcerative colitis - Initial application	
Ulcerative colitis - Renewal	
Olderative Collids - Netlewal	2/3

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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PATIENT NHI:	REFERRER Reg No:		
First Names:	First Names:		
Surname:	Surname:		
DOB:	Address:		
Address:			
	Fax Number:		
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  Patient has a CDAI score of greater than or equal to 300 or HBI score of greater than or equal to 10  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 has experienced an inadequate response to, or intolerable side effects from, prior therapy with immunom and corticosteroids			
vals valid for 2 years.			
100 points from the CDAI score, or HBI score has record HBI is 4 or less ed an adequate response to treatment but CDAI score uses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every non-response to treatment for re-induction. Another on cycle. Up to 10 mg/kg every 8 weeks (or equivaler	e and/or HBI score cannot be assessed  very 8 weeks (or equivalent) can be used for up er re-induction may be considered sixteen weeks		
	Surname:  DOB:  Address:  greater than or equal to 300 or HBI score of greater to intestine disease affecting more than 50 cm of the smort gut syndrome or would be at risk of short gut syndrode an inadequate response to, or intolerable side effection and inadequate response to, or intolerable side effection and inadequate response to treatment but CDAI score and an adequate response to treatment but CDAI score and an adequate response to treatment but CDAI score and an adequate response to treatment for re-induction. Another the contraction is the contraction of the contraction in the contractio		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:  Infliximab - continued		Fax Number:				
or Patient has extensive small	ovals valid for 6 months.  no's disease  of greater than or equal to 30					
Patient has tried but experienced corticosteroids	an inadequate response to, or intolerable side effects	from, prior therapy with immunomodulators and				
or PCDAI score is 15 or less						
Infliximab to be administered at doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every 8 weeks (or equivalent) can be used for up to 3 doses if required for secondary non-response to treatment for re-induction. Another re-induction may be considered sixteen weeks after completing the last re-induction cycle. Up to 10 mg/kg every 8 weeks (or equivalent) may be used for patients treated with this dose prior to 1 February 2019						
Initial application — Graft vs host disease Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  Patient has steroid-refractory acute graft vs. host disease of the gut						
Prerequisites(tick box where appropriate)	ovals valid without further renewal unless notified.	in refractory to other tractments				
Patient has life-threatening pulmonary sarcoidosis diagnosed by a multidisciplinary team that is refractory to other treatments						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Prerequisites(tick boxes where appropriate)  Patient has acute, fulminant ulcera	ctitioner on the recommendation of a gastroenterolog	gist. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)  The patient has had an initial Speciand	ioner on the recommendation of a rheumatologist. A	cept for ankylosing spondylitis
or	d intolerable side effects from a reasonable trial of ad imumab and/or etanercept treatment, the patient did is spondylitis	
Renewal — ankylosing spondylitis		
Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Approximately a property of the reatment, BASDAI has improved by 4 or more points	
and Physician considers that the patier	nt has benefited from treatment and that continued tre	eatment is appropriate
infliximab to be administered at do	oses no greater than 5 mg/kg every 6-8 weeks	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			np or st	icker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					First Names:	First Names:
Name	e:				Surname:	Surname:
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumbe	ər:				Fax Number:
Inflix	kima	<b>b</b> - co	ntinued			
App	licatio	ons fron	n any re	ronic ocular inflammati elevant practitioner. Appro s where appropriate)		
and		The patient has expe	al Special Authority approval for adalimumab for chrorienced intolerable side effects from adalimumab			
			L	The patient has received ocular inflammation	ed insufficient benefit from adalimumab to meet the r	enewal criteria for adalimumab for chronic
	or	and	or C	Patient is 18 years or  Patient is under 18 years  Patient is under 8 years	older and treatment with at least two other immunomars and treatment with methotrexate has proven ineffacts and treatment with steroids or methotrexate has plisease requires control to prevent irreversible vision least	odulatory agents has proven ineffective ective or is not tolerated at a therapeutic dose roven ineffective or is not tolerated at a
Ren	Renewal — chronic ocular inflammation					
Appl	icatio	ns from	any re	er (if known):levant practitioner. Appros s where appropriate)	vals valid for 12 months.	
The patient has had a good clinical r				ent has had a good clinica	al response following 3 initial doses	
Following each 12 month treatme Nomenclature (SUN) criteria < ½+ cystoid macular oedema)			lomenc	lature (SUN) criteria < ½+	nt period, the patient has had a sustained reduction in anterior chamber or vitreous cells, absence of active	
	or				nt period, the patient has a sustained steroid sparing of ice daily if under 18 years old	effect, allowing reduction in prednisone to < 10mg
	Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible rision loss if infliximab is withdrawn.					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:		
Infliximab - continued				
Initial application — fistulising Crohn's disease Applications from any relevant practitioner. Appropriete (tick boxes where appropriate)  Patient has confirmed Crohn's disease Applications.	vals valid for 6 months.			
Patient has one or more cor  or  Patient has one or more rec  or  Patent has complex peri-and				
or There has been a marked re reduction in the Fistula Asse  and Infliximab to be administered at do	g fistulae have decreased from baseline by at least 5 eduction in drainage of all fistula(e) from baseline (in the sament score), together with less induration and patients up to 5 mg/kg every 8 weeks. Up to 10 mg/kg every non-response to treatment for re-induction. Another	the case of adult patients, as demonstrated by a ent reported pain  very 8 weeks (or equivalent) can be used for up		
prior to 1 February 2019  Initial application — neurosarcoidosis	on cycle. Up to 10 mg/kg every 8 weeks (or equivaler			
Applications only from a neurologist or Practitioner on the recommendation of a neurologist. Approvals valid for 18 months.  Prerequisites(tick boxes where appropriate)				
and Patient has CNS involvement and Patient has steroid-refractory disea and IV cyclophosphamide has be or				
	i i i i i i i i i i i i i i i i i i i			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:		
Infliximab - continued				
Renewal — neurosarcoidosis				
Current approval Number (if known):  Applications only from a neurologist or Practitioner  Prerequisites(tick boxes where appropriate)	on the recommendation of a neurologist. Approvals	valid for 18 months.		
A withdrawal period has been tried	and the patient has relapsed			
	n considered but would not be clinically appropriate			
and There has been a marked reduction in prednisone dose and				
l   —   —	provement in MRI appearances			
or Marked improvement	n other symptomology			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name	e:				Surname:	Surname:
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumbe	r:				Fax Number:
Inflix	kimal	<b>b</b> - co	ntinu	ed		
App	licatio	ns only	y fror	The patient has had an initial psoriasis	vant practitioner on the recommendation of a dermate	ept or secukinumab for severe chronic plaque
Patient has experienced intolerable side effects from adalimumab, etanercept or seculor  Patient has received insufficient benefit from adalimumab, etanercept or secukinumal adalimumab, etanercept or secukinumab for severe chronic plaque psoriasis  or			cukinumab to meet the renewal criteria for			
		and	or or	greater than 10, where  Patient has severe chrohave been present for all least 6 months from than 10  Patient has tried, but had an	dy" severe chronic plaque psoriasis with a Psoriasis of lesions have been present for at least 6 months from onic plaque psoriasis of the face, or palm of a hand of at least 6 months from the time of initial diagnosis onic localised genital or flexural plaque psoriasis who om the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis, and with a Dermatol of the time of initial diagnosis.	or sole of a foot, where the plaque or plaques ere the plaques or lesions have been present ogy Life Quality Index (DLQI) score greater ced intolerable side effects from, at least three
	and  A PASI assessment has been completed for at least the most recent prior treatment course (but preferably all prior treatment courses), preferably while still on treatment but no longer than 1 month following cessation of each prior treatment course  The most recent PASI assessment is no more than 1 month old at the time of initiation				ent course (but preferably all prior treatment cessation of each prior treatment course	
while face seve	Note: "Inadequate response" is defined as: for whole body severe chronic plaque psoriasis, a PASI score of greater than 10, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment; for severe chronic plaque psoriasis of the face, hand, foot, genital or flexural areas at least 2 of the 3 PASI symptom subscores for erythema, thickness and scaling are rated as severe or very severe, and for the face, palm of a hand or sole of a foot the skin area affected is 30% or more of the face, palm of a hand or sole of a foot, as assessed preferably while still on treatment but no longer than 1 month following cessation of the most recent prior treatment					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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	amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
g No:		First Names:	First Names:
ıme:		Surname:	Surname:
ldress:		DOB:	Address:
		Address:	
			Fax Number:
fliximab - co	ontinued		
pplications fron	al Number (if known):m any relevant practitioner. Approick boxes where appropriate)  Patient had "whole boand		atment
or	Following each prior i sustained at this level	nfliximab treatment course the patient has a PASI scot, when compared with the pre-infliximab treatment ba	seline value
or	Patient had severe chand  Patient had severe chand  Following each all 3 of erythem course baseline  Following each affected, or sus	nronic plaque psoriasis of the face, or palm of a hand or prior infliximab treatment course the patient has a rectal, thickness and scaling, to slight or better, or sustain	or sole of a foot at the start of treatment duction in the PASI symptom subscores for ed at this level, as compared to the treatment duction of 75% or more in the skin area treatment baseline value

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APPLICANT (stamp or sticker acceptable)		or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name	):				Surname:	Surname:
Addre	ess:				DOB:	Address:
					Address:	
Fax N	lumber	r:				Fax Number:
Inflix	imab	<b>)</b> - c	ontin	ued		
App	lication	ns fro	om ar tick be	previous use by relevant practitioner. Appropriate previous where appropriate) Int was being treated with inflication was being treated with inflication with the properties of the properties o	ximab prior to 1 February 2019	
Initis	al anni	icati	on_	neoriatic arthritie		
App	lication	ns on	ıly fro	<ul> <li>psoriatic arthritis</li> <li>m a rheumatologist or Practition</li> <li>oxes where appropriate)</li> </ul>	oner on the recommendation of a rheumatologist. Ap	oprovals valid for 4 months.
	and ,		The ¡	patient has had an initial Spec	cial Authority approval for adalimumab and/or etanero	ept and/or secukinumab for psoriatic arthritis
		or		The patient has experienced	l intolerable side effects from adalimumab and/or etail	nercept and/or secukinumab
					treatment with adalimumab and/or etanercept and/or nab and/or etanercept and/or secukinumab for psoria	

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Name:         Surname:         Surname:           Address:         DOB:         Address:           Address:	APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:			
Address:	Reg No:		First Names:	First Names:			
Fax Number: Fax Nu	Name	:	Surname:	Surname:			
Fax Number: Fax Number: Fax Number: Infliximab - continued  Renewal — psoriatic arthritis  Current approval Number (if known): Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months. Prerequisites(tick boxes where appropriate)	Addre	ss:	DOB:	Address:			
Fax Number: Fax Number: Fax Number: Infliximab - continued  Renewal — psoriatic arthritis  Current approval Number (if known):			Address:				
Renewal — psoriatic arthritis							
Current approval Number (if known):	Fax N	umber:		Fax Number:			
Current approval Number (if known):	Inflix	imab - continued					
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)    Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician   The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician   Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks    Initial application — rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.   Prerequisites(tick boxes where appropriate)    The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis   The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept	Rene	ewal — psoriatic arthritis					
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)    Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician   The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician   Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks    Initial application — rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.   Prerequisites(tick boxes where appropriate)    The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis   The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept	Curre	ent approval Number (if known):					
Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician  Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks  Initial application — rheumatoid arthritis  Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept and/or etanercept  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):  Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolera		, ,		provals valid for 6 months.			
clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician  Initial application — rheumatoid arthritis  Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  and  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):	Prere	equisites(tick boxes where appropriate)					
clinically significant response to treatment in the opinion of the physician  The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician  Initial application — rheumatoid arthritis  Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  and  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):		Following 2 to 4 months' in	tial treatment, the nations has at least a 50% decrease	o in active joint count from baceline and a			
The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to prior infliximab treatment in the opinion of the treating physician   Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks		clinically significant respons		e in active joint count from baseline and a			
Initial application — rheumatoid arthritis  Applications only from a rheumatoid gist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  or Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):		The patient demonstrates at		ount from baseline and a clinically significant			
Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks  Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks  Infliximab to be administered at doses no greater than 5 mg/kg every 8 weeks  Infliximab polication — rheumatoid arthritis Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):			treatment in the opinion of the treating physician				
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  and  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):			ses no greater than 5 mg/kg every 8 weeks				
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  and  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept intolerance  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):	1 141-	t and the state of					
The patient has had an initial Special Authority approval for adalimumab and/or etanercept for rheumatoid arthritis  The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept and Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):	Appl	lications only from a rheumatologist or Practit	ioner on the recommendation of a rheumatologist. Ap	oprovals valid for 4 months.			
The patient has experienced intolerable side effects from a reasonable trial of adalimumab and/or etanercept  or Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept and Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):							
Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept  and  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):			cial Authority approval for adalimumab and/or etanerc	ept for rheumatoid arthritis			
Following at least a four month trial of adalimumab and/or etanercept, the patient did not meet the renewal criteria for adalimumab and/or etanercept  and  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):			d intolerable side effects from a reasonable trial of ada	alimumab and/or etanercept			
Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Renewal — rheumatoid arthritis  Current approval Number (if known):		Following at least a four more	nth trial of adalimumab and/or etanercept, the patient	did not meet the renewal criteria for adalimumab			
Renewal — rheumatoid arthritis  Current approval Number (if known):							
Current approval Number (if known):			unct to methotrexate therapy or monotherapy where us	se of methotrexate is limited by toxicity or			
Current approval Number (if known):	Rene	Ponowal rhoumatoid arthritic					
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a	110110						
Prerequisites(tick boxes where appropriate)  Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  and  Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a		, ,					
intolerance  Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a							
Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count from baseline and a			unct to methotrexate therapy or monotherapy where us	se of methotrexate is limited by toxicity or			
		and					
		clinically significant respons		e in active joint count from baseline and a			
The patient demonstrates at least a continuing 30% improvement in active joint count from baseline and a clinically significant response to treatment in the opinion of the physician		The patient demonstrates at		ount from baseline and a clinically significant			
and Infliximab to be administered at doses no greater than 3 mg/kg every 8 weeks			ses no greater than 3 mg/kg every 8 weeks				

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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:			
Infliximab - continued					
The patient has severe ocul	isease which is significantly impacting the patient's quark of the patient of the				
or  The patient has severe gast	treatment(s) appropriate for the particular symptom(s) (see Notes)  The patient has severe gastrointestinal, rheumatologic and/or mucocutaneous symptoms and has not responded adequately to two or more treatment appropriate for the particular symptom(s) (see Notes)  and				
measured using an appropriate quality of life scale Treatments appropriate for the particular symptom intravenous/oral steroids and other immunosuppre	Note: Behcet's disease diagnosed according to the International Study Group for Behcet's Disease. Lancet 1990;335(8697):1078-80. Quality of life measured using an appropriate quality of life scale such as that published in Gilworth et al J Rheumatol. 2004;31:931-7.  Treatments appropriate for the particular symptoms are those that are considered standard conventional treatments for these symptoms, for example intravenous/oral steroids and other immunosuppressants for ocular symptoms; azathioprine, steroids, thalidomide, interferon alpha and ciclosporin for mucocutaneous symptoms; and colchicine, steroids and methotrexate for rheumatological symptoms.				
Renewal — severe Behcet's disease					
and		quality of life			
Parameter determinant of the second of the s					
Renewal — fulminant ulcerative colitis  Current approval Number (if known):					
reassessed every 6 months and Infliximab to be administered at do to 3 doses if required for secondar	sonsidered appropriate, infliximab should be used in considered appropriate, infliximab should be used in conserving the second of the second	very 8 weeks (or equivalent) can be used for uper re-induction may be considered sixteen weeks			

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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:	
Infliximab - continued				
or The patient has experience or The patient has received occular inflammation  Or Patient has severe, vision-the and Treatment with high-doineffective at controllin or Patient developed new or		Special Authority approval for adalimumab for sever enced intolerable side effects from adalimumab ed insufficient benefit from adalimumab to meet the relatening ocular inflammation requiring rapid control use steroids (intravenous methylprednisolone) followed symptoms  inflammatory symptoms while receiving high dose so years and treatment with high dose oral steroids ar	enewal criteria for adalimumab for severe  ed by high dose oral steroids has proven teroids	
Renewal — severe ocular inflammation  Current approval Number (if known):				
Nomenclature (SUN) criteria < ½+ cystoid macular oedema)		t period, the patient has had a sustained reduction in anterior chamber or vitreous cells, absence of active	vitreous or retinal lesions, or resolution of uveitic	
daily, or steroid	d drops less than twic	period, the patient has a sustained steroid sparing of eduly if under 18 years old		
Note: A trial withdrawal should be considered after every 24 months of stability, unless the patient is deemed to have extremely high risk of irreversible vision loss if infliximab is withdrawn.				

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APPLICANT (stamp or sticker acceptable)  PATIENT NHI:					
Reg No:	First Names:	First Names:			
Name:	Surname:	Surname:			
Address:	DOB:	Address:			
	Address:				
Fax Number:Infliximab - continued		Fax Number:			
Initial application — ulcerative colitis Applications from any relevant practitioner. App Prerequisites(tick boxes where appropriate)	rovals valid for 6 months.				
Patient has active ulcerative colit	is				
Patients SCCAI is greater	·				
Patients PUCAI score is gi	reater than or equal to 20				
Patient has tried but has experie immunomodulators and systemic	nced an inadequate response to, or has experienced is corticosteroids	ntolerable side effects from, prior therapy with			
Renewal — ulcerative colitis					
Current approval Number (if known):					
Applications from any relevant practitioner. Appr <b>Prerequisites</b> (tick boxes where appropriate)	ovals valid for 2 years.				
rerequisites(tick boxes where appropriate)					
The SCCAl score has redu	uced by 2 points or more from the SCCAI score when t	the patient was initiated on infliximab			
	uced by 10 points or more from the PUCAI score when	the patient was initiated on infliximab			
to 3 doses if required for second	doses up to 5 mg/kg every 8 weeks. Up to 10 mg/kg eary non-response to treatment for re-induction. Anothetion cycle. Up to 10 mg/kg every 8 weeks (or equivale	er re-induction may be considered sixteen weeks			
Initial application — pyoderma gangrenosum Applications only from a dermatologist. Approva <b>Prerequisites</b> (tick boxes where appropriate)					
Patient has pyoderma gangrenos					
azathioprine, or methotrexate) ar	ns of conventional therapy including a minimum of thre and not received an adequate response	e pharmaceuticals (e.g. prednisone, ciclosporine,			
A maximum of 8 doses					
Note: Note: Indications marked with * are unant	proved indications				

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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:		
Infliximab - continued				
Renewal — pyoderma gangrenosum				
Current approval Number (if known):				
Initial application — inflammatory bowel arthrital Applications from any relevant practitioner. Approprietes (tick boxes where appropriate)				
Patient has a diagnosis of active u	lcerative colitis or active Crohn's disease			
Patient has had axial inflammatory	y pain for six months or more			
Patient is unable to take NSAIDs				
	demonstrated by radiological imaging or MRI			
Patient's disease has not responded adequately to prior treatment consisting of at least 3 months of an exercise regime s physiotherapist				
Patient has a BASDAI of at least 6 pharmacological treatment	on a 0 - 10 scale completed after the 3 month exer	rcise trial, but prior to ceasing any previous		
Renewal — inflammatory bowel arthritis – axial				
Current approval Number (if known):				
Treatment has resulted in an improvement in BASDAI of 4 or more points from pre-treatment baseline on a 10-point scale, or an improvement in BASDAI of 50%, whichever is less				

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APPLI	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name:		Surname:	Surname:
Addres	ss:	DOB:	Address:
		Address:	
Fax Nu			Fax Number:
Initial Appli	application — inflammatory bowel arthritications from any relevant practitioner. Approquisites(tick boxes where appropriate)  Patient has a diagnosis of active unterpreted and patient has active arthritis in at leasternoclavicular and patient has tried and not experience (unless contraindicated)  Patient has tried and not experience contraindicated)  Patient has tried and not experience contraindicated)  Patient has a CRP level greater or Patient has an ESR greater or	locerative colitis or active Crohn's disease ust four joints from the following: hip, knee, ankle, subset of a response to at least three months of methotrexe and a response to at least three months of sulfasalazing ater than 15 mg/L measured no more than one month than 25 mm per hour measured no more than one mode as patient is currently receiving prednisone therapy	ate or azathioprine at a maximum tolerated dose ine at a maximum tolerated dose (unless in prior to the date of this application onth prior to the date of this application
Rene	wal — inflammatory bowel arthritis – peri	pheral	
Curre	nt approval Number (if known):		
	eations from any relevant practitioner. Approx quisites(tick boxes where appropriate)	vals valid for 2 years.	
	or response to treatment in the opinion	has experienced at least a 50% decrease in active jo on of the physician continuing 30% improvement in active joint count fro	
Appli	application — immune checkpoint inhibit cations from any relevant practitioner. Approquisites(tick boxes where appropriate)		
	The individual requires treatment f malignancy	or moderate to severe autoimmune toxicity following	immune checkpoint inhibitor treatment for
The individual has received insufficient benefit from use of corticosteroids			
	and Infliximab is to be administered at	up to 5mg/kg for up to four doses	

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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:		
Infliximab - continued				
Renewal — immune checkpoint inhibitor toxici	ty in malignancy*			
Current approval Number (if known):				
Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)				
The individual has shown clinical improvement and ongoing treatment is required and				
Infliximab is to be administered at up to 5mg/kg for up to a total of 8 doses				
Note: Indications marked with * are unapproved indications.				

### SA2489 - Tocilizumab

Rheumatoid Arthritis - Initial application
Rheumatoid Arthritis (patients previously treated with adalimumab or etanercept) - Initial application
Adult-onset Still's disease - Initial application
Adult-onset Still's disease - Renewal
Cytokine release syndrome - Initial application
Idiopathic multicentric Castleman's disease - Initial application       282         Idiopathic multicentric Castleman's disease - Renewal       283         Immune checkpoint inhibitor toxicity in malignancy* - Initial application       283         Immune checkpoint inhibitor toxicity in malignancy* - Renewal       284         Moderate to severe COVID-19 - Initial application       282         Polyarticular juvenile idiopathic arthritis - Initial application       281         Polyarticular juvenile idiopathic arthritis - Renewal       283
Idiopathic multicentric Castleman's disease - Renewal       283         Immune checkpoint inhibitor toxicity in malignancy* - Initial application       283         Immune checkpoint inhibitor toxicity in malignancy* - Renewal       284         Moderate to severe COVID-19 - Initial application       282         Polyarticular juvenile idiopathic arthritis - Initial application       281         Polyarticular juvenile idiopathic arthritis - Renewal       283
Immune checkpoint inhibitor toxicity in malignancy* - Initial application       283         Immune checkpoint inhibitor toxicity in malignancy* - Renewal       284         Moderate to severe COVID-19 - Initial application       282         Polyarticular juvenile idiopathic arthritis - Initial application       281         Polyarticular juvenile idiopathic arthritis - Renewal       283
Immune checkpoint inhibitor toxicity in malignancy* - Renewal       284         Moderate to severe COVID-19 - Initial application       282         Polyarticular juvenile idiopathic arthritis - Initial application       281         Polyarticular juvenile idiopathic arthritis - Renewal       283
Moderate to severe COVID-19 - Initial application282Polyarticular juvenile idiopathic arthritis - Initial application281Polyarticular juvenile idiopathic arthritis - Renewal283
Polyarticular juvenile idiopathic arthritis - Initial application
Polyarticular juvenile idiopathic arthritis - Renewal
Previous use - Initial application
Systemic juvenile idiopathic arthritis - Initial application
Systemic juvenile idiopathic arthritis - Renewal

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APPLICANT (stamp or sticker acceptable)		T (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name	:		Surname:	Surname:
Addre	ss:		DOB:	Address:
			Address:	
Fax Number:		r:		Fax Number:
App	lication	ites(tick boxes where appropriate)	vals valid without further renewal unless notified.	
The patient has developed grade 3 or 4 cytokine release syndrome associated with the treatment of acute lymphoblastic leukaemia  and  Tocilizumab is to be administered at doses no greater than 8 mg/kg IV for a maximum of 12 mg/kg)				
	or	The patient has developed 0 therapy for the treatment of and	e Malaghan Institute of Medical Research ENABLE tri CRS or Immune Effector Cell-Associated Neurotoxicity relapsed or refractory B-cell non-Hodgkin lymphoma tered according to the consensus guidelines for CRS a maximum of 3 doses	y Syndrome (ICANS) following CAR T-cell
App	lication	lication — previous use ns from any relevant practitioner. Appro ites(tick boxes where appropriate)	vals valid for 6 months.	
	and	Patient was being treated with toci	izumab prior to 1 February 2019	
		Rheumatoid arthritis		
		or Systemic juvenile idiopathic	arthritis	
		or Adult-onset Still's disease		
		or Polyarticular juvenile idiopati	hic arthritis	
		or Idiopathic multicentric Castle	eman's disease	

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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:
Tocilizumab - continued		
Prerequisites (tick boxes where appropriate)  The patient has had an initial Speand  The patient has experienced or  The patient has received instance the renewal criterial and  The patient is seronegative or  The patient has been and  The patient has been At four months	cial Authority approval for adalimumab and/or etaneror distribution of a rheumatologist. Application of a rheumatologist. Application of a description of adalimumab and/or etaneror distribution of the control of a for rheumatoid arthritis.  In the control of the control of the control of adal of the control of the contr	ept for rheumatoid arthritis hercept alimumab and/or etanercept such that they do lies and rheumatoid factor th NZ Hospital

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APPLICANT (stamp or sticker acceptable)		(stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No	):		First Names:	First Names:	
Name:			Surname:	Surname:	
Addres	s:		DOB:	Address:	
			Address:		
Fax Nu	mber:			Fax Number:	
Tocilia	zuma	ab - continued			
Applic	cations	es(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Appears on the recommendation of a rheumatologist. Appears on the recommendation of a rheumatologist. Appears on the recommendation of longer of the recommendation of longer		
	and _ and _	Tocilizumab is to be used as mono	_		
	Patient has tried and not resp combination with another age  Patient has tried and not resp combination with another age  and  Patient has persistent sympto  or		esponded to at least three months therapy at the maximum tolerated dose of ciclosporin alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months therapy at the maximum tolerated dose of leflunomide alone or in gent esponded to at least three months three months are three months at least 20 active, swollen, tender joints esponded to at least three months are three months at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints esponded to at least 20 active, swollen, tender joints espo		
Patient has a C-reactive protein level greater than 15 mg/L measured no more than one month prior to the date of the corrective protein levels not measured as patient is currently receiving prednisone therapy at a dose of greater than 15 mg/L measured no more than one month prior to the date of the correction of the					
	2-9, 4.16 1.166 40.11 00.10 1.161 1.161 1.161				
Initial application — systemic juvenile idiopathic Applications only from a rheumatologist or Practition Prerequisites(tick boxes where appropriate)			ic arthritis oner on the recommendation of a rheumatologist. A	oprovals valid for 6 months.	
Patient diagnosed with systemic juvenile idiopathic arthritis					
	Patient has tried and not responded to a reasonable trial of all of the following, either alone or in combination: oral or parenteral methotrexate: non-steroidal anti-inflammatory drugs (NSAIDs); and systemic corticosteroids				

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APPL	APPLICANT (stamp or sticker acceptable)			sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	Reg No:				First Names:	First Names:
Name:					Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbei	r:				Fax Number:
Tocil	izum	<b>1ab</b> - <i>c</i>	onti	inued		
App	lication	ns only	from	adult-onset Still's disease n a rheumatologist or Practit kes where appropriate)	ioner on the recommendation of a rheumatologist. A	pprovals valid for 6 months.
The patient has had an initial Special Authority approval for adalimumab and/or e (AOSD)				nd/or etanercept for adult-onset Still's disease		
		and		The patient has been	started on tocilizumab for AOSD in a Health NZ Hosp	pital
			or	The patient has exper	rienced intolerable side effects from adalimumab and	/or etanercept
			·.		ved insufficient benefit from at least a three-month tria renewal criteria for AOSD	al of adalimumab and/or etanercept such that
	or		_			
		and		Patient diagnosed with AOS	D according to the Yamaguchi criteria (J Rheumatol	1992;19:424-430)
		L		Patient has tried and not res antiinflammatory drugs (NS)	sponded to at least 6 months of glucocorticosteroids a AIDs) and methotrexate	at a dose of at least 0.5 mg/kg, non-steroidal
		and		Patient has persistent symp	toms of disabling poorly controlled and active disease	e
App	lication	ns only	from	polyarticular juvenile idiop n a rheumatologist or Practit kes where appropriate)	pathic arthritis ioner on the recommendation of a rheumatologist. A	pprovals valid for 4 months.
		The patient has had an initia	al Special Authority approval for both etanercept and	adalimumab for polyarticular course juvenile		
		and	]	The patient has experienced	d intolerable side effects, or has received insufficient l	benefit from, both etanercept and adalimumab
	or	and	]	Treatment with a tumour ned	crosis factor alpha inhibitor is contraindicated	
		and		Patient has had polyarticula	r course JIA for 6 months duration or longer	
		and	] .	To be used as an adjunct to	methotrexate therapy or monotherapy where use of	methotrexate is limited by toxicity or intolerance
	methotrexate (at			s and at least 3 joints with limited range of motion, panaximum tolerated dose)	ain or tenderness after a 3-month trial of	
	tolerated dose)			ease activity (cJADAS10 score of at least 2.5) after a	3-month trial of methotrexate (at the maximum	
			or	Low disease activity (	cJADAS10 score between 1.1 and 2.5) after a 6-mon	th trial of methotrexate

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Tocilizumab - continued			
Initial application — idiopathic multicentric Cas Applications only from a haematologist, rheumato 6 months. Prerequisites(tick boxes where appropriate)	stleman's disease logist or Practitioner on the recommendation of a hae	ematologist or rheumatologist. Approvals valid for	
Patient has severe HHV-8 negative	e idiopathic multicentric Castleman's disease		
Treatment with an adequate trial o	f corticosteroids has proven ineffective		
	doses no greater than 8 mg/kg IV every 3-4 weeks		
Initial application — moderate to severe COVID-19 Applications from any relevant practitioner. Approvals valid for 4 weeks.  Prerequisites(tick boxes where appropriate)			
Patient has confirmed (or probable	e) COVID-19		
Oxygen saturation of < 92% on roo	om air, or requiring supplemental oxygen		
Patient is receiving adjunct system	ic corticosteroids, or systemic corticosteroids are cor	ntraindicated	
and	at doses no greater than 8mg/kg IV for a maximum of		
and Tocilizumab is not to be administer			
Toomzamab to not to be administer	ed in combination with sarotimb		
Renewal — Rheumatoid Arthritis			
Current approval Number (if known):			
Applications only from a rheumatologist or Practition  Prerequisites(tick boxes where appropriate)	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
significant response to treatment in	ent, the patient has at least a 50% decrease in active not the opinion of the physician	joint count from baseline and a clinically	
	patient demonstrates at least a continuing 30% impresament in the opinion of the physician	ovement in active joint count from baseline and a	
Renewal — systemic juvenile idiopathic arthriti	is		
Current approval Number (if known):  Applications only from a rheumatologist or Practitic		provals valid for 6 months.	
Applications only from a rheumatologist or Practitioner on the recommendation of a rheumatologist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)			
improvement criteria (ACR Pedi 30	eatment, the patient has achieved at least an America )) response from baseline	an College of Rheumatology paediatric 30%	
On subsequent reapplications, the	patient demonstrates at least a continuing ACR Pedi	30 response from baseline	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Tocilizumab - continued			
Renewal — adult-onset Still's disease			
Current approval Number (if known):			
	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
Prerequisites(tick box where appropriate)			
The patient has a sustained improvemer	nt in inflammatory markers and functional status		
Renewal — polyarticular juvenile idiopathic art	hritis		
Current approval Number (if known):			
	oner on the recommendation of a rheumatologist. Ap	provals valid for 6 months.	
Prerequisites(tick boxes where appropriate)			
Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance			
Following 3 to 4 months' initial treatment, the patient has at least a 50% decrease in active joint count and an improvement in physician's global assessment from baseline			
On subsequent reapplication	ns, the patient demonstrates at least a continuing 30% hysician's global assessment from baseline	6 improvement in active joint count and	
Renewal — idiopathic multicentric Castleman's	s disease		
Current approval Number (if known):			
Applications only from a haematologist, rheumatol 12 months.	ogist or Practitioner on the recommendation of a hae	matologist or rheumatologist. Approvals valid for	
Prerequisites(tick box where appropriate)			
The treatment remains appropriate and the patient has a sustained improvement in inflammatory markers and functional status			
Initial application — immune checkpoint inhibitor toxicity in malignancy* Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)			
malignancy	or moderate to severe autoimmune toxicity following i	mmune checkpoint inhibitor treatment for	
l l . <del></del>	cient benefit from use of corticosteroids		
and Tocilizumab is to be administered	at a maximum dose of 8 mg/kg fortnightly		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Name:         Surname:         Surname:           Address:         Address:         Address:           Fax Number:         Fax Number:         Fax Number:	APPLICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Address:	Reg No:	First Names:	First Names:		
Address:  Fax Number: Fax Number:  Focilizumab - continued  Renewal — immune checkpoint inhibitor toxicity in malignancy*  Current approval Number (if known):	Name:	Surname:	Surname:		
Fax Number: Fax Number:  Fax Number: Fax Number:  Fax Number: Fax Number:  Fax Number: Fax Number: Fax Number:  Fax Number: Fa	Address:	DOB:	Address:		
Fax Number: Fax Nu		Address:			
Renewal — immune checkpoint inhibitor toxicity in malignancy*  Current approval Number (if known):					
Renewal — immune checkpoint inhibitor toxicity in malignancy*  Current approval Number (if known):	Fax Number:		Fax Number:		
Current approval Number (if known):	Tocilizumab - continued				
Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick boxes where appropriate)  The individual has shown clinical improvement and ongoing treatment is required  Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly	Renewal — immune checkpoint inhibitor toxici	ty in malignancy*			
Prerequisites(tick boxes where appropriate)  The individual has shown clinical improvement and ongoing treatment is required  and  Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly	Current approval Number (if known):				
and Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly					
Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly	· · · · · · · · · · · · · · · · · · ·				
Note: Indications marked with * are unapproved indications.	Tocilizumab is to be administered at a maximum dose of 8 mg/kg fortnightly				
	Note: Indications marked with * are unapproved indications.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Reg No:		First Names:	First Names:		
Name:		Surname:	Surname:		
Address:		DOB:	Address:		
		Address:			
Fax Numbe	r:		Fax Number:		
Trastuzu	mab emtansine				
Application	lication — early breast cancer as only from a relevant specialist or med ites(tick boxes where appropriate)	lical practitioner on the recommendation of a relevant	t specialist. Approvals valid for 12 months.		
and	Patient has early breast cancer ex	pressing HER2 IHC3+ or ISH+			
and	Documentation of pathological inv	asive residual disease in the breast and/or axiliary ly	mph nodes following completion of surgery		
and	Patient has completed systemic no	eoadjuvant therapy with trastuzumab and chemothera	apy prior to surgery		
and	Disease has not progressed durin	g neoadjuvant therapy			
and	Patient has left ventricular ejection	fraction of 45% or greater			
		continued at disease progression			
					Total adjuvant treatment duration
Application	lication — metastatic breast cancer as only from a relevant specialist or any ites(tick boxes where appropriate)	relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 6 months.		
and	Patient has metastatic breast cand	eer expressing HER-2 IHC 3+ or ISH+ (including FISH	H or other current technology)		
and	Patient has previously received tra	Patient has previously received trastuzumab and chemotherapy, separately or in combination			
	The patient has received pri	or therapy for metastatic disease*			
		ase recurrence during, or within six months of comple	eting adjuvant therapy*		
and and	Patient has a good performance status (ECOG 0-1)				
	Patient does not have symp	tomatic brain metastases			
		s and has received prior local CNS therapy			
and					
	or Patient has not received price	or funded trastuzumab emtansine or trastuzumab der	ruxtecan treatment		
	Patient has discontinu	ed trastuzumab deruxtecan due to intolerance			
		ogress while on trastuzumab deruxtecan			
and Treatment to be discontinued at disease progression					

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Reg No:	First Names:	First Names:		
Name:	Surname:	Surname:		
Address:	DOB:	Address:		
	Address:			
Fax Number:		Fax Number:		
Trastuzumab emtansine - continued				
Renewal — metastatic breast cancer				
Current approval Number (if known):				
Applications only from a relevant specialist or medical practitioner on the recommendation of a relevant specialist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)				
The cancer has not progressed at any time point during the previous approval period whilst on trastuzumab emtansine and				
Treatment to be discontinued at disease progression				
Note: Prior or adjuvant therapy includes anthracycline, other chemotherapy, biological drugs, or endocrine therapy.				

### SA2233 - Rituximab

ABO-incompatible organ transplant - Initial application	288
ANCA associated vasculitis - Initial application	
ANCA associated vasculitis - Renewal	288
Antibody-mediated organ transplant rejection - Initial application	288
B-cell acute lymphoblastic leukaemia/lymphoma* - Initial application	304
CD20+ low grade or follicular B-cell NHL - Initial application	
CD20+ low grade or follicular B-cell NHL - Renewal	
Chronic lymphocytic leukaemia - Initial application	289
Chronic lymphocytic leukaemia - Renewal	290
Membranous nephropathy - Initial application	
Membranous nephropathy - Renewal	
Neuromyelitis Optica Spectrum Disorder - Renewal	
Neuromyelitis Optica Spectrum Disorder(NMOSD) - Initial application	290
Post-transplant - Initial application	291
Post-transplant - Renewal	
Severe Refractory Myasthenia Gravis - Initial application	
Severe Refractory Myasthenia Gravis - Renewal	292
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRNS) -	Initial application
293	πιται αρριισατίο
Steroid dependent nephrotic syndrome (SDNS) or frequently relapsing nephrotic syndrome (FRN	IS) - Benewal
293	io, rionovai
Steroid resistant nephrotic syndrome (SRNS) - Initial application	293
Steroid resistant nephrotic syndrome (SRNS) - Renewal	
Aggressive CD20 positive NHL - Initial application	
Aggressive CD20 positive NHL - Renewal	204
Anti-NMDA receptor autoimmune encephalitis - Initial application	
Anti-NMDA receptor autoimmune encephalitis - Renewal	
Desensisation prior to transplant - Initial application	304
Graft versus host disease - Initial application	200
Haemophilia with inhibitors - Initial application	205
Haemophilia with inhibitors - Renewal	205
Immune thrombocytopenic purpura (ITP) - Initial application	205
Immune thrombocytopenic purpura (TTP) - Renewal	206
Immunoglobulin G4-related disease (IgG4-RD*) - Initial application	206
Immunoglobulin G4-related disease (IgG4-RD*) - Renewal	306
Indolent, low-grade lymphomas or hairy cell leukaemia* - Initial application	200
Indolent, low-grade lymphomas or hairy cell leukaemia* - Renewal	206
Pemiphigus* - Initial application	
Pemiphigus* - Renewal	
Pure red cell aplasia (PRCA) - Initial application	
Pure red cell aplasia (PRCA) - Renewal	207
Severe antisynthetase syndrome - Initial application	297
Severe antisynthetase syndrome - Renewal	
Severe chronic inflammatory demyelinating polyneuropathy - Initial application	301
Severe critoric imiaminatory demyerinating polyneuropatiny - neriewai	301
Severe cold haemagglutinin disease (CHAD) - Initial application	29/
Thrombotic thrombocytopenic purpura (TTP) - Initial application	298
Tractment refractory overtamic lunua crythometecus (CLE) Initial conficction	298
Treatment refractory systemic lupus erythematosus (SLE) - Initial application	298
Treatment refractory systemic lupus erythematosus (SLE) - Renewal	299
Warm autoimmune haemolytic anaemia (warm AIHA) - Initial application	299
Warm autoimmune haemolytic anaemia (warm AIHA) - Renewal	299

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Name:	Surname:	Surname:		
Address:	DOB:	Address:		
	Address:			
Fax Number:		Fax Number:		
Rituximab (Riximyo)				
Initial application — ABO-incompatible organ to Applications from any relevant practitioner. Appropries (tick box where appropriate)  Patient is to undergo an ABO-incompatibn Note: Indications marked with * are unapproved in	vals valid without further renewal unless notified.  le solid organ transplant*			
and	vals valid for 8 weeks.	·		
or	cumulative dose of cyclophosphamide > 15 g or a foult in a cumulative dose > 15 g  notrexate are contraindicated	urther repeat 3 month induction course of		
Note: Indications marked with * are unapproved in	dications.			
Renewal — ANCA associated vasculitis				
Current approval Number (if known):  Applications from any relevant practitioner. Approvement of the properties of				
and	NCA associated vasculitis*  o treatment with rituximab but is now experiencing ar exceed the equivalent of 375 mg/m² of body-surface			
Note: Indications marked with * are unapproved in	dications.			
Initial application — Antibody-mediated organ transplant rejection  Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  Patient has been diagnosed with antibody-mediated organ transplant rejection*				
	Note: Indications marked with * are unapproved indications.			

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g No:		First Names:	First Names:
me:		Surname:	Surname:
dress:		DOB:	Address:
		Address:	
			Fax Number:
uximab	(Riximyo) - continued		
pplications	ration — Chronic lymphocytic leuk from any relevant practitioner. Appro es(tick boxes where appropriate)		
and _	The patient has progressive Binet	stage A, B or C chronic lymphocytic leukaemia (CLL)	) requiring treatment
	The patient is rituximab trea	atment naive	
		therapy treatment naive	
	or The patient's d	isease has relapsed following no more than three pric	or lines of chemotherapy treatment
	The patient has	s had a treatment-free interval of 12 months or more inide chemotherapy	f previously treated with fludarabine and
	The patient's disease has rewith funded venetoclax	elapsed within 36 months of previous treatment and ri	ituximab treatment is to be used in combination
and and	The patient has good performanc	e status	
		chromosome 17p deletion CLL	
	Rituximab treatment is to be	e used in combination with funded venetoclax for rela	osed/refractory chronic lymphocytic leukaemia
and	Rituximab to be administered in c 6 treatment cycles	ombination with fludarabine and cyclophosphamide, b	pendamustine or venetoclax for a maximum of
and	It is planned that the patient receibendamustine or venetoclax	ves full dose fludarabine and cyclophosphamide (oral	ly or dose equivalent intravenous administration),
own stand tients temp	ard therapeutic chemotherapy regime	udes small lymphocytic lymphoma. A line of chemoth en and supportive treatments. 'Good performance sta se symptoms a higher ECOG (2 or 3) is acceptable v 2.	atus' means ECOG score of 0-1, however, in

<u> </u>	_	
Cianad.	Doto:	
Sidiled.	 Date.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Addres	ss:	DOB:	Address:	
		Address:		
Fax Nu	umber:		Fax Number:	
Ritux	imab (Riximyo) - continued			
Renev	wal — Chronic lymphocytic leuka	emia		
Applic	ent approval Number (if known): cations from any relevant practitioner equisites(tick boxes where appropria	. Approvals valid for 12 months.		
	The patient's diseas with funded venetor		evious treatment and rituximab treatment is to be used in combination	
	The patient's		e than one prior line of treatment with rituximab for CLL	
and			n interval of 36 months or more since commencement of initial rituximab treatment	
	and It is planned t		abine and cyclophosphamide (orally or dose equivalent intravenous	
	and  Rituximab to be administered in combination with fludarabine and cyclophosphamide, bendamustine or venetoclax for a maximum of 6 treatment cycles			
		.L)' includes small lymphocytic lymphory regimen and supportive treatments.	ma. A line of chemotherapy treatment is considered to comprise a	
Appli	l application — Neuromyelitis Optications only from a relevant specialis equisites (tick boxes where appropria	st or medical practitioner on the recomn	nendation of a relevant specialist. Approvals valid for 6 months.	
	One of the following dose weekly for four weeks	regimens is to be used: 2 doses of 1,00	00 mg rituximab administered fortnightly, or 4 doses of 375 mg/m2 administer	
		erienced a severe episode or attack of re attack of NMOSD)	NMOSD (rapidly progressing symptoms and clinical investigations	
	The patient ha	as experienced a breakthrough attack o	of NMOSD	
	The patient is	receiving treatment with mycophenolat	e	
	and The patients i	s receiving treatment with corticosteroic	ab ab	
L				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
		Fax Number:	
Rituximab (Riximyo) - continued			
Renewal — Neuromyelitis Optica Spectrum Dis	sorder		
Prerequisites(tick boxes where appropriate)	is is to be used: 2 doses of 1,000 mg rituximab admirementation of a relevant	t specialist. Approvals valid for 2 years.  nistered fortnightly, or 4 doses of 375 mg/m2 administered	
The patient has B-cell post-transpland To be used for a maximum of 8 tre  Note: Indications marked with * are unapproved in	eatment cycles		
Renewal — Post-transplant			
Current approval Number (if known):			
and The patient has B-cell post-transpl			
and To be used for no more than 6 treat	atment cycles		
Note: Indications marked with * are unapproved in	dications.		

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Rituximab (Riximyo) - continued		
One of the following dose regimen weekly for four weeks, or two 1,00 and  Treatment with corticosteroic or  Treatment with at lease	actitioner on the recommendation of a neurologist. A s is to be used: 375 mg/m2 of body surface area per 0 mg doses given two weeks apart ds and at least one other immunosuppressant for at least one other immunosuppressant for a period of at least peen trialed for at least 12 months and have been discovered.	east a period of 12 months has been ineffective
Renewal — Severe Refractory Myasthenia Grav  Current approval Number (if known):  Applications only from a neurologist or medical pra  Prerequisites(tick boxes where appropriate)		oprovals valid for 2 years.

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Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Rituximab (Riximyo) - continued		
Applications only from a nephrologist or Practition  Prerequisites(tick boxes where appropriate)  Patient is a child with SDNS* or Fland  Treatment with steroids for at least and  Treatment with ciclosporin for at leand  Treatment with mycophenolate for and	t a period of 3 months has been ineffective or associated that a period of 3 months has been ineffective and/or at least a period of 3 months with no reduction in disculd not exceed the equivalent of 375 mg/m <sup>2</sup> of body su	ated with evidence of steroid toxicity discontinued due to unacceptable side effects ease relapses
Current approval Number (if known):	er on the recommendation of a nephrologist. Approve	als valid for 8 weeks.
Patient who was previously treated with rituximab for nephrotic syndrome*  Treatment with rituximab was previously successful and has demonstrated sustained response for greater than 6 months, be condition has relapsed and the patient now requires repeat treatment  The total rituximab dose used would not exceed the equivalent of 375 mg/m² of body surface area per week for a total of 4 vertical indications marked with * are unapproved indications.		
Initial application — Steroid resistant nephrotic Applications only from a nephrologist or Practition Prerequisites(tick boxes where appropriate)	c syndrome (SRNS) ner on the recommendation of a nephrologist. Approv	als valid for 8 weeks.
Patient is a child with SRNS* when	re treatment with steroids and ciclosporin for at least 3 months has been ineffective	3 months have been ineffective
Genetic causes of nephrotic syndr	rome have been excluded  Ild not exceed the equivalent of 375 mg/m² of body su	urface area per week for a total of 4 weeks
The tetal maximus door dead wor		and and por front for a total of a fronto

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Reg No:	First Names:	First Names:		
Name:	Surname:	Surname:		
Address:	DOB:	Address:		
	Address:			
Fax Number:		Fax Number:		
Rituximab (Riximyo) - continued				
Renewal — Steroid resistant nephrotic syndro	me (SRNS)			
Current approval Number (if known):				
, ,	er on the recommendation of a nephrologist. Approve	als valid for 8 weeks.		
Prerequisites(tick boxes where appropriate)				
Patient who was previously treate	d with rituximab for nephrotic syndrome*			
and Treatment with rituximab was prev	riously successful and has demonstrated sustained re	esponse for greater than 6 months, but the		
	tient now requires repeat treatment	opense ist greater than a memory carrier		
	uld not exceed the equivalent of 375 mg/m² of body st	urface area per week for a total of 4 weeks		
Note: Indications marked with * are unapproved in	ndications.			
Initial application — aggressive CD20 positive	NHI			
Applications from any relevant practitioner. Appro				
Prerequisites(tick boxes where appropriate)				
The patient has treatment n	aive aggressive CD20 positive NHL			
and	nt chemotherapy regimen given with curative intent			
and				
To be used for a maximum	of 8 treatment cycles			
or				
The patient has aggressive and	CD20 positive NHL with relapsed disease following p	rior chemotherapy		
To be used for a maximum	of 6 treatment cycles			
Note: 'Aggressive CD20 positive NHL' includes la	rge B-cell lymphoma and Burkitt's lymphoma/leukaen	nia		
Renewal — aggressive CD20 positive NHL				
Current approval Number (if known):				
Applications from any relevant practitioner. Appro				
Prerequisites (tick boxes where appropriate)				
The patient has had a rituximab tr	eatment-free interval of 12 months or more			
and				
The patient has relapsed refractor				
To be used with a multi-agent che	motherapy regimen given with curative intent			
To be used for a maximum of 4 tre	eatment cycles			
Note: 'Aggressive CD20 positive NHL' includes la	rge B-cell lymphoma and Burkitt's lymphoma/leukaen	nia		

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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:
Initial application — haemophilia with inhibitors Applications only from a haematologist or Practitio Prerequisites(tick boxes where appropriate)  Patient has mild congenital haemo	ner on the recommendation of a haematologist. App	
Prerequisites(tick boxes where appropriate)	ner on the recommendation of a haematologist. App rituximab for haemophilia with inhibitors 12 months was demonstrated	rovals valid for 4 months.
Initial application — immune thrombocytopenic Applications only from a haematologist or Practition Prerequisites(tick boxes where appropriate)	purpura (ITP) uner on the recommendation of a haematologist. App	provals valid for 8 weeks.
or	ocytopenic purpura* with a platelet count of less than ocytopenic purpura* with a platelet count of 20,000 to	
or Treatment with steroids has I	splenectomy have been ineffective been ineffective and splenectomy is an absolute conteroids have been ineffective and patient is being pre	
The total rituximab dose used would Note: Indications marked with * are unapproved in	ld not exceed the equivalent of 375 mg/m2 of body s	urface area per week for a total of 4 weeks

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Reg No:		First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Ritux	kimab (Riximyo) - continued			
Rene	ewal — immune thrombocytopenic purpur	a (ITP)		
Appli	ent approval Number (if known):cations only from a haematologist or Practition equisites (tick boxes where appropriate)	ner on the recommendation of a haematologist. App	rovals valid for 8 weeks.	
	Previous treatment with lower dose (375 mg/m² weekly for 4 weeks) is	es of rituximab (100 mg weekly for 4 weeks) have pro	oven ineffective and treatment with higher doses	
		ed with rituximab for immune thrombocytopenic purpu	ıra*	
	An initial response lasting at and	least 12 months was demonstrated		
	Patient now requires repeat	treatment		
Note	: Indications marked with * are unapproved in	dications.		
App	al application — indolent, low-grade lymph lications from any relevant practitioner. Appro equisites(tick boxes where appropriate)			
	· · · · · · · · · · · · · · · · · · ·	r grade NHL or hairy cell leukaemia* with relapsed dis	sease following prior chemotherapy	
	and To be used for a maximum of	of 6 treatment cycles		
	or			
	The patient has indolent, low	v grade lymphoma or hairy cell leukaemia* requiring	first-line systemic chemotherapy	
	To be used for a maximum of	of 6 treatment cycles		
	Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.			
Rene	ewal — indolent, low-grade lymphomas or	hairy cell leukaemia*		
Curre	ent approval Number (if known):			
	cations from any relevant practitioner. Appro- equisites(tick boxes where appropriate)	vals valid for 12 months.		
	The patient has had a rituximab tro	eatment-free interval of 12 months or more		
		e NHL or hairy cell leukaemia* with relapsed disease	following prior chemotherapy	
	To be used for no more than 6 trea	atment cycles		
Note indic	Note: 'Indolent, low-grade lymphomas' includes follicular, mantle, marginal zone and lymphoplasmacytic/Waldenstrom macroglobulinaemia. *Unapproved indication. 'Hairy cell leukaemia' also includes hairy cell leukaemia variant.			

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Name:	Surname:	Surname:		
Address:	DOB:	Address:		
	Address:			
Fax Number:		Fax Number:		
Rituximab (Riximyo) - continued				
Prerequisites(tick box where appropriate)  Patient has autoimmune pure red cell ap	ner on the recommendation of a haematologist. Applace of the recommendation of a haematologist. Applace of the recommendation of a haematologist. Applace of the recommendation of a haematologist.			
Note: Indications marked with * are unapproved in	dications.			
Renewal — pure red cell aplasia (PRCA)				
Current approval Number (if known):				
	ner on the recommendation of a haematologist. Appr	rovals valid for 6 weeks.		
Prerequisites(tick box where appropriate)				
Patient was previously treated with rituxin demonstrated an initial response lasting Note: Indications marked with * are unapproved in	nab for pure red cell aplasia* associated with a demo at least 12 months dications.	nstrable B-cell lymphoproliferative disorder and		
Initial application — severe cold haemagglutini Applications only from a haematologist or Practitic Prerequisites(tick boxes where appropriate)	n disease (CHAD) ner on the recommendation of a haematologist. App	provals valid for 8 weeks.		
Patient has cold haemagglutinin di	sease*			
Patient has severe disease which i	s characterized by symptomatic anaemia, transfusion	n dependence or disabling circulatory symptoms		
and The total rituximab dose used wou	ld not exceed the equivalent of 375 mg/m2 of body so	urface area per week for a total of 4 weeks		
Note: Indications marked with * are unapproved in	dications.			
Renewal — severe cold haemagglutinin disease	(CHAD)			
There was a service sold indemlaggia.	(CIAE)			
Current approval Number (if known):				
Applications only from a haematologist or Practitioner on the recommendation of a haematologist. Approvals valid for 8 weeks.  Prerequisites (tick boxes where appropriate)				
(375 mg/m <sup>2</sup> weekly for 4 weeks) is	es of rituximab (100 mg weekly for 4 weeks) have pro now planned	oven ineffective and treatment with higher doses		
Patient was previously treate	d with rituximab for severe cold haemagglutinin disea	ase*		
	least 12 months was demonstrated			
and Patient now requires repeat	treatment			
Note: Indications marked with * are unapproved in	dications.			

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Rituximab (Riximyo) - continued			
Initial application — thrombotic thrombocyto Applications only from a haematologist or Pract Prerequisites(tick boxes where appropriate)	penic purpura (TTP) itioner on the recommendation of a haematologist. Ap	oprovals valid for 8 weeks.	
The total rituximab dose used w	ould not exceed the equivalent of 375 mg/m2 of body	surface area per week for a total of 4 weeks	
Patient has thrombotic thr thrombocytopenia despite	ombocytopenic purpura* and has experienced progres plasma exchange ic thrombotic thrombocytopenic purpura* with neurolo		
		giodi di dalabadada patribiogy	
Note: Indications marked with * are unapproved	indications.		
Renewal — thrombotic thrombocytopenic pu	irpura (TTP)		
Current approval Number (if known):			
Applications only from a haematologist or Practi Prerequisites(tick boxes where appropriate)	tioner on the recommendation of a haematologist. Ap	provals valid for 8 weeks.	
Patient was previously treated w	rith rituximab for thrombotic thrombocytopenic purpura	*	
An initial response lasting at lea	st 12 months was demonstrated		
Patient now requires repeat trea	tment		
and The total rituximab dose used w	ould not exceed the equivalent of 375 mg/m2 of body	surface area per week for a total of 4 weeks	
Note: Indications marked with * are unapproved	indications.		
Initial application — treatment refractory sys Applications only from a rheumatologist, nephromonths.  Prerequisites(tick boxes where appropriate)	temic lupus erythematosus (SLE)  logist or Practitioner on the recommendation of a rhe	umatologist or nephrologist. Approvals valid for 7	
	ately life- or organ-threatening SLE*		
and The disease has proved refractor	ory to treatment with steroids at a dose of at least 1 mg	g/kg	
	ring prior treatment for at least 6 months with maximal phamide, or cyclophosphamide is contraindicated	tolerated doses of azathioprine, mycophenolate	
and Maximum of four 1000 mg infus			
Note: Indications marked with * are unapproved	indications.		

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Reg No:	First Names:	First Names:
Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Rituximab (Riximyo) - continued		
Renewal — treatment refractory systemic lupu	s erythematosus (SLE)	
Current approval Number (if known):		
	gist or Practitioner on the recommendation of a rheun	natologist or nephrologist. Approvals valid for 6
months. <b>Prerequisites</b> (tick boxes where appropriate)		
Patient's SI E* achieved at least a	partial response to the previous round of prior rituxim	nah treatment
and		nd troumont
The disease has subsequently rela		
Maximum of two 1000 mg infusion		
Note: Indications marked with * are unapproved in	dications.	
Initial application — warm autoimmune haemo	lytic anaemia (warm AIHA) oner on the recommendation of a haematologist. App	provale valid for 9 weeks
Prerequisites (tick boxes where appropriate)	The of the recommendation of a flaematologist. App	novais valid for 6 weeks.
Patient has warm autoimmune had	emolytic anaemia*	
and		
> 5 mg prednisone daily), cytotoxid	s been ineffective: steroids (including if patient requicagents (e.g. cyclophosphamide monotherapy or in a	
The total rituximab dose used wou	ld not exceed the equivalent of 375 mg/m2 of body s	urface area per week for a total of 4 weeks
Note: Indications marked with * are unapproved in	dications.	
Renewal — warm autoimmune haemolytic ana	emia (warm AIHA)	
•		
Current approval Number (if known):	ner on the recommendation of a haematologist. App	royals valid for 8 wooks
Prerequisites(tick boxes where appropriate)	ner on the recommendation of a fidefilatologist. App	Tovais valid for 6 weeks.
Previous treatment with lower dos	es of rituximab (100 mg weekly for 4 weeks) have pro	oven ineffective and treatment with higher doces
(375 mg/m² weekly for 4 weeks) is		over menetive and treatment with higher doses
	ed with rituximab for warm autoimmune haemolytic ar	naemia*
and An initial response lasting at	least 12 months was demonstrated	
and		
Patient now requires repeat	rreatment	
Note: Indications marked with * are unapproved in	dications.	

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Reg No:		First Names:	First Names:	
Name:		Surname:	Surname:	
Addres	SS:	DOB:	Address:	
		Address:		
Fax Nu	ımber:		Fax Number:	
Ritux	imab (Riximyo) - continued			
Appli	application — severe antisynthetase syn cations from any relevant practitioner. Appro quisites(tick boxes where appropriate)	vals valid for 12 months.		
	Patient has confirmed antisyntheta  and Patient has severe, immediately life and	e or organ threatening disease, including interstitial l	ung disease	
	or azathioprine) has not be effe	munosuppressants (oral steroids, cyclophosphamide ective at controlling active disease due to life threatening complications as of rituximab	, methotrexate, mycophenolate, ciclosporin,	
Rene	wal — severe antisynthetase syndrome			
Applio	nt approval Number (if known):eations from any relevant practitioner. Approv quisites(tick boxes where appropriate)			
	strength and pulmonary function	o the previous rituximab treatment with demonstrated	l improvement in inflammatory markers, muscle	
	The patient has not received rituximab in the previous 6 months and			
	Maximum of two cycles of 2 × 1,00	00mg infusions of rituximab given two weeks apart		
Appli	application — graft versus host disease cations from any relevant practitioner. Approquisites(tick boxes where appropriate)	vals valid without further renewal unless notified.		
	Patient has refractory graft versus	host disease following transplant		
	Treatment with at least 3 immunos controlling active disease	suppressants (oral steroids, ciclosporin, tacrolimus, m	nycophenolate, sirolimus) has not be effective at	
	The total rituximab dose used wou	ld not exceed the equivalent of 375 mg/m <sup>2</sup> of body si	urface area per week for a total of 4 weeks	

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Rituximab (Riximyo) - continued			
Prerequisites (tick boxes where appropriate)  Patient has severe chronic inflamn and  Treatment with steroic active disease and  At least one other immeffective at controlling or  Rapid treatment is required and  One of the following dose regiment	natory demyelinating polyneuropathy (CIPD)  Is and intravenous immunoglobulin and/or plasma explanations discussed in the second of the second	change has not been effective at controlling crolimus, mycophenolate) has not been	
Prerequisites(tick boxes where appropriate)  Patient's disease has responded to to baseline and The patient has not received rituxing and One of the following dose regimen	actitioner on the recommendation of a neurologist. Ap	improvement in neurological function compared	

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Reg No:		First Names:	First Names:	
Name: .		Surname:	Surname:	
Address:		DOB:	Address:	
		Address:		
Fax Num	ber:		Fax Number:	
Rituxin	nab (Riximyo) - continued			
Applica	pplication — anti-NMDA receptor autoir tions only from a neurologist or medical pruisites(tick boxes where appropriate)	nmune encephalitis actitioner on the recommendation of a neurologist. A	Approvals valid for 6 months.	
aı	Patient has severe anti-NMDA rec	eptor autoimmune encephalitis		
	active disease  At least one other immeffective at controlling			
	Rapid treatment is required	due to life threatening complications		
aı	One of the following dose regimen weekly for four weeks, or two 1,00	s is to be used: 375 mg/m2 of body surface area pe 0 mg doses given two weeks apart	er week for a total of four weeks, or 500 mg once	
Renewa	al — anti-NMDA receptor autoimmune e	ncephalitis		
Current	approval Number (if known):			
Applicat		actitioner on the recommendation of a neurologist. A	pprovals valid for 6 months.	
aı	Patient's disease has responded to	the previous rituximab treatment with demonstrated	d improvement in neurological function	
	The patient has not received rituxi	mab in the previous 6 months		
aı	nd The patient has experienced a rela	apse and now requires further treatment		
aı		s is to be used: 375 mg/m2 of body surface area pe 0 mg doses given two weeks apart	er week for a total of four weeks, or 500 mg once	
Applica	pplication — CD20+ low grade or follicutions from any relevant practitioner. Approuisites(tick boxes where appropriate)			
	and	grade or follicular B-cell NHL with relapsed disease f	following prior chemotherapy	
OI	To be used for a maximum or	or o treatifierit cycles		
		grade or follicular B-cell NHL requiring first-line syste	emic chemotherapy	
	To be used for a maximum of	of 6 treatment cycles		

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Rituximab (Riximyo) - continued			
Renewal — CD20+ low grade or follicular B-cell	NHL		
Current approval Number (if known):			
Applications from any relevant practitioner. Approv	rals valid for 24 months.		
Prerequisites(tick boxes where appropriate)			
chemotherapy	nance in CD20+ low grade or follicular B-cell NHL fol	lowing induction with first-line systemic	
Patient is intended to receive rituxi	mab maintenance therapy for 2 years at a dose of 37	'5 mg/m2 every 8 weeks (maximum of 12 cycles)	
Initial application — Membranous nephropathy Applications only from a nephrologist or any releva Prerequisites(tick boxes where appropriate)	ant practitioner on the recommendation of a nephrolo	gist. Approvals valid for 6 weeks.	
Patient has biopsy-proven pr	imary/idiopathic membranous nephropathy*		
	with no evidence of secondary cause, and an eGFR	of > 60ml/min/1.73m2	
Patient remains at high risk of progmeasures (see Note)	ression to end-stage kidney disease despite more th	an 3 months of treatment with conservative	
	exceed the equivalent of 375mg/m2 of body surface	area per week for a total of 4 weeks	

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Name:	Surname:	Surname:	
Address:	DOB:	Address:	
	Address:		
Fax Number:		Fax Number:	
Renewal — Membranous nephropathy			
Current approval Number (if known):	ant practitioner on the recommendation of a nephrolo	gist. Approvals valid for 6 weeks.	
and  Treatment with rituximab wa treatment  or  Patient achieved partial resp	n rituximab for membranous nephropathy*  s previously successful, but the condition has relapse  conse to treatment and requires repeat treatment (see	e Note)	
Note:			
a) Indications marked with * are unapproved indic			
	sease defined as > 5g/day proteinuria. sin system blockade, blood-pressure management, c ess contraindicated or the patient has experienced int		
	einuria of at least 50% from baseline, and between 0		
Initial application — B-cell acute lymphoblastic Applications only from a relevant specialist or med Prerequisites(tick boxes where appropriate)	c leukaemia/lymphoma* dical practitioner on the recommendation of a relevan	nt specialist. Approvals valid for 2 years.	
Patient has newly diagnosed B-ce	II acute lymphoblastic leukaemia/lymphoma*		
and	with an intensive chemotherapy protocol with curativ		
	t exceed the equivalent of 375 mg/m <sup>2</sup> per dose for a r	maximum of 18 doses	
Note: Indications marked with * are unapproved in	ndications.		
Initial application — desensisation prior to trar Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)			
Patient requires desensitisation pr	ior to mismatched allogenic stem cell transplant*		
	n two doses at 375 mg/m2 of body-surface area		
Note: Indications marked with * are unapproved in	lote: Indications marked with * are unapproved indications.		

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Reg N	۱o:		First Names:	First Names:	
Name	):		Surname:	Surname:	
Addre	ess:		DOB:	Address:	
			Address:		
Fax N	lumbei	r:		Fax Number:	
Ritu	kimal	<b>b</b> (Riximyo) - continued			
App	lication	Patient has severe rapidly prand  Is used in combination with sand  Skin involvement is at	systemic corticosteroids (20 mg/day)  least 5% body surface area  volvement (10 or more mucosal erosions) or diffuse g	gingivitis or confluent large erosions	
		and	adequate clinical benefit from systemic corticosteroic indicated	ds (20 mg/day) in combination with a steroid	
Note	: Indic	cations marked with * are unapproved in	dications.		
Ren	ewal –	– pemiphigus*			
Appl	ication	proval Number (if known):s only from a dermatologist or relevant sites(tick boxes where appropriate)	specialist. Approvals valid for 6 months.		
	and	Patient has experienced adequate ulceration and reduction in corticos	clinical benefit from rituximab treatment, with improv steroid requirement	ement in symptoms and healing of skin	
	[	Patient has not received rituximab	in the previous 6 months		
Note	: Indic	cations marked with * are unapproved in	dications.		

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Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Rituximab (Riximyo) - continued		
Initial application — immunoglobulin G4-related Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)		
Patient has confirmed diagnosis of	IgG4-RD*	
or lowering corticosteroid dose  Treatment with corticosteroid toxicity or intolerance	Is and/or disease modifying anti-rheumatic drugs for below 5 mg per day (prednisone equivalent) without its and/or disease modifying anti-rheumatic drugs is contexceed a maximum of two 1000 mg infusions of ridications.	relapse contraindicated or associated with evidence of
Renewal — immunoglobulin G4-related disease	e (IgG4-RD*)	
Current approval Number (if known):		
Treatment with rituximab for but the condition has relapse or Patient is receiving maintena		sease has demonstrated sustained response,
and Rituximab re-treatment not to be gi	ven within 6 months of previous course of treatment s of rituximab given two weeks apart	
Note: Indications marked with * are unapproved indications.		

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APPLICANT (stamp or sticker acceptable)		amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name: .	Name:		Surname:	Surname:
Address:			DOB:	Address:
			Address:	
Fax Num	ber:			Fax Number:
Mepoli	zuma	b		
Initial a	pplicat	tion — Severe eosinophilic asthm	na linical immunologist. Approvals valid for 12 months.	
а	nd	Patient must be aged 12 years or or Patient must have a diagnosis of s	older severe eosinophilic asthma documented by a respirate	pry physician or clinical immunologist
а	nd	-	vocal cord dysfunction, central airway obstruction, br	
	nd	Patient has a blood eosinophil cou	int of greater than 0.5 × 10^9 cells/L in the last 12 mo	nths
			ised asthma therapy including inhaled corticosteroids acting beta-2 agonist, or budesonide/formoterol as par not tolerated	
a	or	defined as either documente	ed use of oral corticosteroids for at least 3 days or particular oral corticosteroids for at least 3 days or particular oral corticosteroids of at least the equivalent of 1	renteral corticosteroids
	and Treatment is not to be used in con		abination with subsidised benralizumab	
а	nd		st (ACT) score of 10 or less. Baseline measurements be made at the time of application, and again at arou	
ď	or	Patient has not previously re	eceived an anti-IL5 biological therapy for their severe	eosinophilic asthma
		Patient was refractory	or intolerant to previous anti-IL5 biological therapy	
		Patient was not eligible of commencing treatments	e to continue treatment with previous anti-IL5 biologic nent	cal therapy and discontinued within 12 months
		evere eosinophilic asthma		
Applicat	tions or	,	linical immunologist. Approvals valid for 2 years.	
a	nd	An increase in the Asthma Control	Test (ACT) score of at least 5 from baseline	
		Exacerbations have been re	duced from baseline by 50% as a result of treatment	with mepolizumab
	or	Reduction in continuous ora	I corticosteroid use by 50% or by 10 mg/day while ma	aintaining or improving asthma control

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Name:	Surname:	Surname:
Address:	DOB:	Address:
	Address:	
Fax Number:		Fax Number:
Prerequisites(tick boxes where appropriate)  The patient has eosinophilic granu and The patient has trialled and not rector to all): azathioprine, cyclophospha	relevant practitioner on the recommendation of a relevant practitioner on the recommendation of a relevant practitioner on the recommendation of a relevant practice. It is a relevant property of the recommendation of the recommendation of the following property of the recommendation of a relevant practice.	ving for at least three months (unless contraindicated rituximab
Renewal — eosinophilic granulomatosis with p		
Current approval Number (if known):		
Applications only from a relevant specialist or any <b>Prerequisites</b> (tick box where appropriate)	relevant practitioner on the recommendation of a rele	vant specialist. Approvals valid for 12 months.
Patient has no evidence of clinical disease	se progression	

### SA2400 - Adalimumab (Amgevita)

Arthritis - oligoarticular course juvenile idiopathic - Initial application	
Arthritis - oligoarticular course juvenile idiopathic - Renewal	
Arthritis - polyarticular course juvenile idiopathic - Initial application	318
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Crohn's disease - adults - Renewal	313
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Crohn's disease - fistulising - Renewal	
Hidradenitis suppurativa - Initial application	
Hidradenitis suppurativa - Renewal	
Ocular inflammation - chronic - Initial application	315
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Ocular inflammation - severe - Renewal	316
Plaque psoriasis - severe chronic - Initial application	311
Plaque psoriasis - severe chronic - Renewal	312
Still's disease - adult-onset (AOSD) - Initial application	321
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Ankylosing spondylitis - Renewal	
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Inflammatory bowel arthritis – peripheral - Renewal	
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Ulcerative colitis - Renewal	
Undifferentiated spondyloarthritis - Initial application	
Undifferentiated spondyloarthritis - Renewal	

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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:	
Adalimumab (Amgevita)			
The patient has severe ocula treatment(s) appropriate for the patient has severe gastr	sease* that is significantly impacting the patient's quar, neurological, and/or vasculitic symptoms and has the particular symptom(s) cointestinal, rheumatological, and/or mucocutaneous propriate for the particular symptom(s)	not responded adequately to one or more	
Initial application — Hidradenitis suppurativa Applications only from a dermatologist. Approvals Prerequisites(tick boxes where appropriate)	valid for 4 months.		
and			
and	ore and the assessment is no more than 1 month old	at time of application	
Renewal — Hidradenitis suppurativa			
Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick boxes where appropriate)	als valid for 2 years.		
The patient has a reduction in active and The patient has a DLQI improvement	re lesions (e.g. inflammatory nodules, abscesses, drent of 4 or more from baseline	aining tistulae) of 25% or more from baseline	

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:				Surname:	Surname:
Address:				DOB:	Address:
				Address:	
Fax Numbe	r:				Fax Number:
Adalimur	nab (	Am	gevita) - continued		
Applicatio	ns only	fronk bo	Patient has had an initial Sp  Patient has experienc	ecial Authority approval for etanercept for severe chreed intolerable side effects  nsufficient benefit to meet the renewal criteria for etanercept.	onic plaque psoriasis
			Fatient has received in	issuilcient benefit to meet the renewal chieffa for etai	lercept for severe chronic plaque psonasis
and		or	present for at least 6 r  Patient has severe cheave been present for  Patient has severe chear for at least 6 months than 10  Patient has tried, but had an following (at maximum toleration)  A PASI assessment or DLQ	le body" severe chronic plaque psoriasis with a PASI score of greater than 10, where lesions have been st 6 months from the time of initial diagnosis  re chronic plaque psoriasis of the face, or palm of a hand or sole of a foot, where the plaque or plaques int for at least 6 months from the time of initial diagnosis  re chronic localised genital or flexural plaque psoriasis where the plaques or lesions have been present in this from the time of initial diagnosis, and with a Dermatology Life Quality Index (DLQI) score greater  and an inadequate response to, or has experienced intolerable side effects from, at least three of the tolerated doses unless contraindicated): phototherapy, methotrexate, ciclosporin, or acitretin  DLQI assessment has been completed for at least the most recent prior treatment course but no longer cessation of each prior treatment course and is no more than 1 month old at the time of application	

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Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Address: .			DOB:	Address:	
			Address:		
		ngevita) - continued		Fax Number:	
Renewal	— Plaque	psoriasis - severe chronic			
Application	ons from an	y relevant practitioner. Appro oxes where appropriate)			
	and	The patient has expe	evere chronic plaque psoriasis at the start of treatmen rienced a 75% or more reduction in PASI score, or is seline value		
or	OI		QI improvement of 5 or more, when compared with th	e pre-treatment baseline value	
	Patient had severe chronic plaque psoriasis of the face, or palm of a hand or sole of a foot at the start of treatment and			e of a foot at the start of treatment	
	OI	slight or better, or sus	rienced reduction in the PASI symptom subscores for tained at this level, as compared to the treatment cou		
		The patient has expe	rienced reduction of 75% or more in the skin area affe aseline value	ected, or sustained at this level, as compared	
or	and	Patient had severe chronic	ocalised genital or flexural plaque psoriasis at the sta	rt of treatment	
	OI	to the pre-treatment b	rienced a reduction of 75% or more in the skin area at asseline value	ffected, or sustained at this level, as compared	
		Patient has a Dermat commencing adalimu	ology Quality of Life Index (DLQI) improvement of 5 o mab	r more, as compared to baseline DLQI prior to	
				-	
Application	Initial application — pyoderma gangrenosum Applications only from a dermatologist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)				
and		ent has pyoderma gangrenosi	ım*		
	azatl	hioprine, or methotrexate) and	s of conventional therapy including a minimum of three d has not received an adequate response	e pharmaceuticals (e.g. prednisone, ciclosporin,	
Note: Ind	lications ma	arked with * are unapproved in	ndications.	ļ.	

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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:		
Adalimumab (Amgevita) - continued				
Initial application — Crohn's disease - adults Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)	vals valid for 6 months.			
Patient has active Crohn's disease				
or	greater than or equal to 300, or HBI score of greater intestine disease affecting more than 50 cm of the sm			
Patient has evidence of showing or	rt gut syndrome or would be at risk of short gut syndr	ome with further bowel resection		
Patient has an ileostomy or	colostomy and has intestinal inflammation			
and Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators		
Renewal — Crohn's disease - adults				
Current approval Number (if known):				
Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)				
CDAI score has reduced by 100 poor	oints from the CDAI score, or HBI score has reduced	by 3 points, from when the patient was initiated		
CDAI score is 150 or less, or HBI i	s 4 or less			
The patient has demonstrated an a	adequate response to treatment, but CDAI score and	or HBI score cannot be assessed		
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 Crohr	n's disease			
Patient has a PCDAI score of	of greater than or equal to 30			
Patient has extensive small	intestine disease			
Patient has tried but had an inaded and corticosteroids	quate response to, or has experienced intolerable sid	e effects from, prior therapy with immunomodulators		

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APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:		
Reg No:		First Names:	First Names:		
Name	:	Surname:	Surname:		
Addre	ss:	DOB:	Address:		
		Address:			
	umber:		Fax Number:		
Adal	imumab (Amgevita) - continued				
Rene	ewal — Crohn's disease - children				
Current approval Number (if known):					
Appl	al application — Crohn's disease - fistulising ications from any relevant practitioner. Appropriates (tick boxes where appropriate)	vals valid for 6 months.			
	Patient has confirmed Crohn's disc	ease			
	Patient has one or more con	nplex externally draining enterocutaneous fistula(e)			
	Patient has one or more rec	tovaginal fistula(e)			
	Patient has complex peri-an	al fistula			
	A Baseline Fistula Assessment ha	s been completed and is no more than 1 month old a	at the time of application		
Rene	ewal — Crohn's disease - fistulising				
Appli	Current approval Number (if known):				
	The number of open draining fistul	ae have decreased from baseline by at least 50%			
		n in drainage of all fistula(e) from baseline as demon n and patient-reported pain	nstrated by a reduction in the Fistula Assessment		

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:					First Names:	First Names:
Name	:				Surname:	Surname:
Addre	ss: .				DOB:	Address:
					Address:	
Fax N	umbe	ər:				Fax Number:
Adal	imu	mab (	<b>A</b> mg	gevita) - continued		
Appl	lication	ons from	any ı	Ocular inflammation - chrorelevant practitioner. Appropriate)		
	or	Th	ie pat	tient has had an initial Spec	cial Authority approval for infliximab for chronic ocular	inflammation
		and	P	Patient has severe uveitis ur	ncontrolled with treatment of steroids and other immu	nosuppressants with a severe risk of vision loss
			or [	Patient is 18 years or	older and treatment with at least two other immunom	odulatory agents has proven ineffective
			or [	Patient is under 18 ye	ars and treatment with methotrexate has proven ineff	ective or is not tolerated at a therapeutic dose
			[		ars and treatment with steroids or methotrexate has p isease requires control to prevent irreversible vision l	
Rene	ewal	— Ocul	ar inf	lammation - chronic		
Curre	ent ai	oproval I	Jumb	er (if known):		
				elevant practitioner. Approv		
Prere	equis	sites(ticl	boxe	es where appropriate)		
		Tr	ie pai	tient has had a good clinica	l response following 12 weeks' initial treatment	
	or	No	omen	clature (SUN) criteria < 1/2+	period, the patient has had a sustained reduction in in anterior chamber or vitreous cells, absence of active	
	or	_ ^		macular oedema)		
					eriod, the patient has a sustained steroid sparing effe ice daily if under 18 years old	ect, allowing reduction in prednisone to < 10mg
Appl	lication	ons from	any i	Ocular inflammation - severelevant practitioner. Appro		
	or	☐ Pa	atient	has had an initial Special A	Authority approval for infliximab for severe ocular infla	mmation
		and	] P	atient has severe, vision-th	reatening ocular inflammation requiring rapid control	
			or [	Treatment with high-d ineffective at controllir	ose steroids (intravenous methylprednisolone) followe	ed by high dose oral steroids has proven
			[	Patient developed nev	v inflammatory symptoms while receiving high dose s	steroids
			or [	Patient is aged under ineffective at controllir	8 years and treatment with high dose oral steroids and symptoms	nd other immunosuppressants has proven

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APPLICANT (stamp or sticker acceptable)		able) PATIENT N	IHI:	REFERRER Reg No:		
Reg No:				First Name	s:	First Names:
Name:				Surname:		Surname:
Addres	ss:			DOB:		Address:
				Address:		
Fax N	umber	:				Fax Number:
Adali	mun	nab (Aı	ngevita) - con	ntinued		
Rene	wal –	- Ocular	inflammation - s	severe		
Curre	nt anr	oroval Nu	mber (if known):			
			,	ioner. Approvals valid for		
Prere	quisi	tes(tick b	oxes where appro	ropriate)		
	[	The	patient has had a	a good clinical response fo	ollowing 3 initial doses	
	or	T Follo	owing each 2 vea	ar treatment period, the pa	itient has had a sustained reduction	in inflammation (Standardisation of Uveitis
		Non		criteria < 1/2+ anterior cha		ctive vitreous or retinal lesions, or resolution of uveitic
	or	_ `			tient has a sustained sternid snaring	effect, allowing reduction in prednisone to < 10mg
				s less than twice daily if un		, cheek, anowing reduction in predimetric to \ rorng
Initia	l anni	lootion	anladacina an	andulitia		
Appli	ication	ns only fro		gist. Approvals valid for 6	months.	
Prere	equisi	tes(tick b	oxes where appro	opriate)		
			Patient has had	d an initial Special Authori	y approval for etanercept for ankylo	sina spondylitis
		and		·		
		o		ent has experienced intole	rable side effects	
			The patie	ent has received insufficie	nt benefit to meet the renewal criteri	a for ankylosing spondylitis
	or					
			Patient has a co	onfirmed diagnosis of ank	ylosing spondylitis for more than six	months
		and	Patient has low	v back pain and stiffness the	nat is relieved by exercise but not by	rest
		and	Patient has bila	ateral sacroiliitis demonstra	ated by radiology imaging	
		and				
				t responded adequately to sise regimen for ankylosing		, while patient was undergoing at least 3 months of
		and	Patient h	as limitation of motion of t	ha lumbar caina in the cagittal and t	he frontal planes as determined by the following
			BASMI m	neasures: a modified Sch	ober's test of less than or equal to 4	he frontal planes as determined by the following cm and lumbar side flexion measurement of less
		o	r $ egin{array}{c} \end{array}$	equal to 10 cm (mean of le		
			Patient h	nas ilmitation of chest expa	insion by at least 2.5 cm below the	average normal values corrected for age and
		and				
					ompleted after the 3 month exercise ld at the time of application	trial, but prior to ceasing any previous pharmacological

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APPL	ICAN	(stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg N	No:		First Names:	First Names:		
Name	e:		Surname:	Surname:		
Addre	ss:		DOB:	Address:		
			Address:			
				Fax Number:		
		nab (Amgevita) - continued				
Rene	ewal –	- ankylosing spondylitis				
Curr	ent ap	proval Number (if known):				
		s from any relevant practitioner. Approv tes(tick box where appropriate)	/als valid for 2 years.			
1	_	,	DAODAL of A consequence of the form of the form			
l		reatment has resulted in an improveme ASDAI of 50%, whichever is less	nt in BASDAI of 4 or more points from pre-treatment I	paseline on a 10 point scale, or an improvement in		
App	licatio	ication — Arthritis - oligoarticular cons only from a named specialist or rheutes(tick boxes where appropriate)	ourse juvenile idiopathic matologist. Approvals valid for 6 months.			
		The patient has had an initia	al Special Authority approval for etanercept for oligoar	ticular course juvenile idiopathic arthritis (JIA)		
		and				
		Patient has experienc	ed intolerable side effects			
			nsufficient benefit to meet the renewal criteria for oligoarticular course JIA			
	or			,		
			methotrexate therapy or monotherapy where use of r	nethotrexate is limited by toxicity or intolerance		
		and Patient has had oligoarticula	ar course JIA for 6 months duration or longer			
		and				
		maximum tolerated do	s with limited range of motion, pain or tenderness afte ose)	r a 3-month trial of methotrexate (at the		
			ase activity (cJADAS10 score greater than 1.5) with p	poor prognostic features after a 3-month trial of		
		methotrexate (at the n	naximum tolerated dose)			
Rene	ewal –	- Arthritis - oligoarticular course juv	enile idiopathic			
Curre	ent ap	proval Number (if known):				
		s from any relevant practitioner. Approx	vals valid for 2 years.			
Pren	equisi	tes(tick boxes where appropriate)				
	or [	Following initial treatment, the pati assessment from baseline	ent has at least a 50% decrease in active joint count	and an improvement in physician's global		
	j. [	On subsequent reapplications, the improvement in physician's global	patient demonstrates at least a continuing 30% imprassessment from baseline	ovement in active joint count and continued		

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APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umbe	r:			Fax Number:
Adal	imur	nab (A	mgevita) - continued		
Initial application — Arthritis - polyarticular could Applications only from a named specialist or rheum Prerequisites (tick boxes where appropriate)  Patient has had an initial Special part of Patient has received in Patient has received in Patient has nad polyarticular and  Patient has had polyarticular and  At least 5 active joints methotrexate (at the more Moderate or high diseat tolerated dose)			om a named specialist or rheu poxes where appropriate)  Patient has had an initial Sp  Patient has experienc  Patient has received in  Patient has nadjunct to  Patient has had polyarticular  At least 5 active joints methotrexate (at the name the moderate or high dise tolerated dose)		methotrexate is limited by toxicity or intolerance lin or tenderness after a 3-month trial of 3-month trial of methotrexate (at the maximum
Rene	ewal –	– Arthrit	is - polyarticular course juve	nile idiopathic	
Appli	Current approval Number (if known):				
	or 	On	essment from baseline subsequent reapplications, the rovement in physician's global	patient demonstrates at least a continuing 30% imprassessment from baseline	ovement in active joint count and continued

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APPLICANT (stamp or sticker acceptable)			mp o	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:					. First Names:	First Names:
Name	):				. Surname:	Surname:
Addre	ess:				. DOB:	Address:
					. Address:	
						Fax Number:
Initia App	al app	lication	on — ly froi	Arthritis - psoriatic m a rheumatologist. Appropriate where appropriate)	vals valid for 6 months.	
		and		Patient has had an initial	Special Authority approval for etanercept or secukinum	nab for psoriatic arthritis
			or	The patient has exp	erienced intolerable side effects	
	or			The patient has rec	eived insufficient benefit from to meet the renewal crite	eria for psoriatic arthritis
		and and and	or	Patient has tried and not recontraindicated)  Patient has persisted  Patient has persisted elbow, knee, ankle,	esponded to at least three months of methotrexate at esponded to at least three months of sulfasalazine or nt symptoms of poorly controlled and active disease in and either shoulder or hip  evel greater than 15 mg/L measured no more than on	leflunomide at maximum tolerated doses (unless n at least 15 swollen joints n at least four joints from the following: wrist,
			or		greater than 25 mm per hour	
					neasured as patient is currently receiving prednisone more than three months	therapy at a dose of greater than 5 mg per day
Rene	ewal –	– Art	hritis	- psoriatic		
Appli	ication	s fror	n any	nber (if known): r relevant practitioner. App oxes where appropriate)	rovals valid for 2 years.	
	0,			wing initial treatment, the p	atient has at least a 50% decrease in swollen joint counysician	unt from baseline and a clinically significant
	or 			nt demonstrates at least a pinion of the treating physic	continuing 30% improvement in swollen joint count fro cian	m baseline and a clinically significant response in

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APPLICANT (stamp or sticker acceptable)			or sticke	er acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:					Surname:	Surname:	
Addre	ss:					DOB:	Address:
						Address:	
Fax N	umbei	r:					Fax Number:
Adal	imun	nab (	An	ngevit	(a) - continued		
App	lication	ns only	fro	m a rhe		al Special Authority approval for etanercept for rheum-	atoid arthritis
				Ш	The patient has receive	red insufficient benefit from etanercept to meet the re	newal criteria for rheumatoid arthritis
	or	and and and and	Treatment is to be used as an adjunct to methotrexate therapy or monotherapy where use of methotrexate is limited by toxicity or intolerance  Patient has tried and not responded to at least three months of methotrexate at a maximum tolerated dose (unless contraindicated)  Patient has tried and not responded to at least three months of methotrexate in combination with sulfasalazine and hydroxychloroquir sulphate at maximum tolerated doses (unless contraindicated)  Patient has tried and not responded to at least three months of methotrexate in combination with the maximum tolerated dose of ciclosporin  Patient has tried and not responded to at least three months of therapy at the maximum tolerated dose of leflunomide alone or in combination with methotrexate				
Curre	ent app	proval s from ites(tic	Nur any k bo	mber (if y releva oxes wh	nt practitioner. Approvere appropriate)		from baseline and a clinically significant
	or [	re	spo	onse to	treatment in the opinion	• •	, ,
	[					patient demonstrates at least a continuing 30% impreatment in the opinion of the physician	ovement in active joint count from baseline and a

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name	:		Surname:	Surname:		
Addre	ss:		DOB:	Address:		
			Address:			
Fax N	umbe	r:		Fax Number:		
Adal	imur	mab (Amgevita) - continued				
App	licatio	lication — Still's disease - adult-onse ns only from a rheumatologist. Approva ites(tick boxes where appropriate)	et (AOSD) als valid without further renewal unless notified.			
		The patient has had an initial Special Authority approval for etanercept and/or tocilizumab for AOSD  Patient has experienced intolerable side effects from etanercept and/or tocilizumab  Patient has received insufficient benefit from at least a three-month trial of etanercept and/or tocilizumab				
	or	_		· · · · · · · · · · · · · · · · · · ·		
	or	Patient has tried and not res methotrexate	D according to the Yamaguchi criteria sponded to at least 6 months of glucocorticosteroids at toms of disabling poorly controlled and active disease			
App	licatio	lication — ulcerative colitis ns from any relevant practitioner. Appro ites(tick boxes where appropriate)	vals valid for 3 months.			
	and	Patient has active ulcerative colitis				
	and	Patient's SCCAI score is gre	·			
	and and	Patient has tried but had an inadequate response to, or has experienced intolerable side effects from prior therapy with immunomodulators and systemic corticosteroids				
		Surgery (or further surgery) is con	sidered to be clinically inappropriate			
Rene	ewal –	– ulcerative colitis				
Appli	ication	proval Number (if known): ns from any relevant practitioner. Approvites (tick boxes where appropriate)				
		The SCCAI score has reduced by	2 points or more from the SCCAI score when the pat	ient was initiated on biologic therapy		
	or 	The PUCAI score has reduced by	10 points or more from the PUCAI score when the pa	tient was initiation on biologic therapy		

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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:
Adalimumab (Amgevita) - continued		
Initial application — undifferentiated spondyloa Applications only from a rheumatologist. Approval Prerequisites(tick boxes where appropriate)		
Patient has undifferentiated periphe wrist, elbow, knee, ankle, and either	eral spondyloarthritis* with active peripheral joint arther shoulder or hip	nritis in at least four joints from the following:
Patient has tried and not responde tolerated doses (unless contraindic	d to at least three months of each of methotrexate, so cated)	ulfasalazine and leflunomide, at maximum
	ater than 15 mg/L measured no more than one month	n prior to the date of this application
or Patient has an ESR greater to	than 25 mm per hour measured no more than one m	onth prior to the date of this application
ESR and CRP not measured done so for more than three	d as patient is currently receiving prednisone therapy months	at a dose of greater than 5 mg per day and has
Note: Indications marked with * are unapproved in	dications	
Demonds and ifferentiated are and described in		
Renewal — undifferentiated spondyloarthritis		
Current approval Number (if known):		
Prerequisites (tick boxes where appropriate)	'ais valid for 2 years.	
Following initial treatment, the patie	ent has at least a 50% decrease in active joint count on the physician	from baseline and a clinically significant
The patient demonstrates at least a in the opinion of the treating physic	a continuing 30% improvement in active joint count frican	rom baseline and a clinically significant response
Initial application — inflammatory bowel arthrit Applications only from a rheumatologist. Approval Prerequisites(tick boxes where appropriate)		
	cerative colitis or active Crohn's disease	
and Patient has axial inflammatory pair	n for six months or more	
and Patient is unable to take NSAIDs		
and Patient has unequivocal sacroiliitis	demonstrated by radiological imaging or MRI	
and	tely to prior treatment consisting of at least 3 months	s of an eversice regime supervised by a
physiotherapist  and	tory to prior treatment consisting of at least 3. Months	s of all excluse regille supervised by a
	scale completed after the 3 month exercise trial, but p	prior to ceasing any previous pharmacological

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APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name	:	Surname:	Surname:
Addre	SS:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Adal	imumab (Amgevita) - continued		
Rene	ewal — inflammatory bowel arthritis – axial		
Curre	ent approval Number (if known):		
	cations from any relevant practitioner. Approv	als valid for 2 years.	
Prere	equisites(tick box where appropriate)		
L	Treatment has resulted in an improvement BASDAI of 50%, whichever is less	nt in BASDAI of 4 or more points from pre-treatment I	paseline on a 10 point scale, or an improvement in
Appl	and Patient has active arthritis in at lead sternoclavicular  Patient has tried and not experience (unless contraindicated)  and Patient has tried and not experience contraindicated)  Patient has tried and not experience contraindicated)  and Patient has a CRP level great or Patient has an ESR greater to or	Icerative colitis or active Crohn's disease st four joints from the following: hip, knee, ankle, subsed a response to at least three months of methotrexacted a response to at least three months of sulfasalazing the subsection of the sulfasalazing that the subsection of the subsection	ne at a maximum tolerated dose ne at a maximum tolerated dose (unless n prior to the date of this application onth prior to the date of this application
Rene	ewal — inflammatory bowel arthritis – perip	pheral	
Appli	ent approval Number (if known): cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)		
	treatment in the opinion of the phys	nas at least a 50% decrease in active joint count from sician	n baseline and a clinically significant response to
	Patient has experienced at least a physician	continuing 30% improvement in active joint count fro	m baseline in the opinion of the treating

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 324 **Form SA2419** 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:
Palivizumab  Initial application  Applications from any relevant practitioner. Approvals yalid for 6 months			
Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Palivizumab to be administered during the annual RSV season  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			

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 325 **Form SA2419** 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:	
Palivizumab - continued			
or  Child has haemodyna and  Child has unope or  Child has unope or  Child has severe or  Child has mode	rals valid for 6 months.	t left to right shunt (see Note B)	
	munity (see Note E) that increase susceptibility to life st	t-threatening viral respiratory infections,	

#### 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

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 326 Form **SA2269** 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:
Gemtuzumab ozogamicin		
Prerequisites(tick boxes where appropriate)  Patient has not received prior cher and Patient has de novo CD33-positive and Patient does not have acute promy and Gemtuzumab ozogamicin will be u and Patient is being treated with curative and Patient's disease risk has been as and Patient must be considered eligible (AraC)	e acute myeloid leukaemia relocytic leukaemia sed in combination with standard anthracycline and c	eytarabine (AraC) iate erapy with standard anthracycline and cytarabine

Note: Acute myeloid leukaemia excludes acute promyelocytic leukaemia and acute myeloid leukaemia that is secondary to another haematological disorder (eg myelodysplasia or myeloproliferative disorder).

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 327 Form SA2151 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:		
Benralizumab				
Initial application — Severe eosinophilic asthma Applications only from a respiratory physician or clin Prerequisites(tick boxes where appropriate)	anical immunologist. Approvals valid for 12 months.			
Patient must be aged 12 years or of and	lder			
Patient must have a diagnosis of se	evere eosinophilic asthma documented by a respirato	ory physician or clinical immunologist		
<del>_</del>	vocal cord dysfunction, central airway obstruction, br	onchiolitis etc. have been excluded		
and Patient has a blood eosinophil coun	at of greater than $0.5 \times 10^9$ cells/L in the last 12 mo	nths		
	sed asthma therapy including inhaled corticosteroids sting beta-2 agonist, or budesonide/formoterol as pa aindicated or not tolerated			
and				
Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids				
Patient has received continuo	ous oral corticosteroids of at least the equivalent of 1	0 mg per day over the previous 3 months		
and Treatment is not to be used in comb	pination with subsidised mepolizumab			
	(ACT) score of 10 or less. Baseline measurements e made at the time of application, and again at around			
	ceived an anti-IL5 biological therapy for their severe	eosinophilic asthma		
Patient was refractory of	or intolerant to previous anti-IL5 biological therapy			
Patient was not eligible of commencing treatment	to continue treatment with previous anti-IL5 biologic	cal therapy and discontinued within 12 months		
Renewal — Severe eosinophilic asthma				
Current approval Number (if known):				
Applications only from a respiratory physician or clin <b>Prerequisites</b> (tick boxes where appropriate)	nical immunologist. Approvals valid for 2 years.			
An increase in the Asthma Control	Test (ACT) score of at least 5 from baseline			
	luced from baseline by 50% as a result of treatment	with benralizumab		
	corticosteroid use by 50% or by 10 mg/day while ma	aintaining or improving asthma control		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 328 **Form SA2182** 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:	
Ustekinumab			
at the time of commencing treatment or  Patient has active Crohn's defects or insufficient to the commencing treatment or  Patient has had an initial effects or insufficient to the commencing treatment or the commencing treatm	ith ustekinumab commenced prior to 1 February 2023 ent	ease and has experienced intolerable side	
Renewal — Crohn's disease - adults  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick boxes where appropriate)			
or therapy  CDAI score is 150 or less, or  The patient has experienced	100 points, or HBI score has reduced by 3 points, from the HBI is 4 or less an adequate response to treatment, but CDAI score to a dose no greater than 90 mg every 8 weeks		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 329 **Form SA2182** June 2025

APPLICANT (stamp or sticker acceptable) PATIENT NHI:				
Reg No:	First Names:	First Names:		
Name:	Surname:	Surname:		
Address:	DOB:	Address:		
	Address:			
Fax Number:		Fax Number:		
Ustekinumab - continued				
at the time of commencing treatment or  Patient has active Crohn's diand  Patient has had an inition benefit to meet renewate and  Patient meets the and	rals valid for 6 months.  ith ustekinumab commenced prior to 1 February 2023 ent  isease  tial approval for prior biologic therapy and has experient al criteria  ne initiation criteria for prior biologic therapies for Crol	enced intolerable side effects or insufficient		
Renewal — Crohn's disease - children*  Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick boxes where appropriate)				
or PCDAI score is 15 or less	y 10 points from when the patient was initiated on bio			
and Ustekinumab to administered at a dose no greater than 90 mg every 8 weeks  Note: Indication marked with * is an unapproved indication.				

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 330 Form **SA2182** June 2025

APPLICANT (stamp or sticker acceptable)			mp or	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:				First Names:	First Names:
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbe	r:				Fax Number:
Uste	kinu	mab	- con	tinued		
Appli	cation	ns fron ites(ti	Patient	Patient has active ulcerative  Patient has had an initive effects or insufficient by the patient meets and meets and meets meets and meets and meets and meets meets meets and meets meets meets and meets meets meets meets and meets m	oth ustekinumab commenced prior to 1 February 2023 ent	plitis and has experienced intolerable side
Rene	wal -	– ulce	erative	colitis		
Curre	ent ap	prova	Numb	per (if known):		
			•	relevant practitioner. Approves where appropriate)	als valid for 12 months.	
				The SCCAI score has reduc	ed by 2 points or more from the SCCAI score since in	nitiation on biologic therapy
		or	F	PUCAI score has reduced by	y 10 points or more from the PUCAI score since initia	tion on biologic therapy*
	and		Jstekir	numab will be used at a dos	e no greater than 90 mg intravenously every 8 weeks	i

I confirm the above details are correct and that in signing this form I understand I may be audited.

Note: Criterion marked with \* is for an unapproved indication.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 331 **Form SA2183** June 2025

APPLICANT (stamp or sticker acceptable)			or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:	
Name:				Surname:	Surname:	
Addre	ss:			DOB:	Address:	
				Address:		
Fax N	umbe	r:			Fax Number:	
Vedo	olizur	mab				
Appl	ication	ns from an	Crohn's disease - adults y relevant practitioner. Appro oxes where appropriate)  ent has active Crohn's disease			
meet renewal criteria (unless or Patient has a CDAI score of or Patient has extensive small or Patient has evidence of sho or Patient has an ileostomy or and Patient has tried but experies from prior therapy with immit			Patient has had an initial apmeet renewal criteria (unless Patient has a CDAI score of Patient has extensive small Patient has evidence of shore Patient has an ileostomy or Patient has tried but experie from prior therapy with imm Patient has experienced into	proval for prior biologic therapy and has experienced is contraindicated)  figreater than or equal to 300, or HBI score of greater intestine disease affecting more than 50 cm of the smort gut syndrome or would be at risk of short gut syndrome colostomy, and has intestinal inflammation  enced an inadequate response to (including lack of initiation)  enced an inadequate response to (including lack of initiation)  enced an inadequate response to (including lack of initiation)	than or equal to 10 nall intestine ome with further bowel resection itial response and/or loss of initial response)	
			Immunomodulators and cor	ticosteroids are contraindicated		
Curro	ent ap	proval Nu is from an	s disease - adults mber (if known): y relevant practitioner. Appro oxes where appropriate)			
	CDAI score has reduced by therapy			100 points, or HBI score has reduced by 3 points, fro	om when the patient was initiated on biologic	
		or _	CDAI score is 150 or less, of	or HBI is 4 or less		
			The patient has experience	d 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						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 332 **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 Num	nber: .			Fax Number:
Vedoliz	zuma	b - continued		
Applica	tions fi	ation — Crohn's disease - children rom any relevant practitioner. Approv s(tick boxes where appropriate)		
а	 nd	Paediatric patient has active Crohr	i's disease	
	Patient has had an initial ap meet renewal criteria (unles		hn's Disease Activity Index (PCDAI) score of greater	
or from prior t		r Patient has experienced into	nced an inadequate response to (including lack of inition including lack of inition in inition including lack of inition in ini	
Note: Ir	ndicati	on marked with * is an unapproved ir	ndication.	
Renewa Current Applica	al — Cappro	Crohn's disease - children*  aval Number (if known):  rom any relevant practitioner. Approx s(tick boxes where appropriate)		
а	o o nd	PCDAI score is 15 or less  The patient has experienced	y 10 points from when the patient was initiated on bio	
Vedolizumab to administered at a dose no greater than 300mg every 8 weeks  Note: Indication marked with * is an unapproved indication.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 333 **Form SA2183** June 2025

APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Addre	ss:		DOB:	Address:	
			Address:		
				Fax Number:	
Initia Appli	I appl	mab - continued  lication — ulcerative colitis ns from any relevant practitioner. Approv ites(tick boxes where appropriate)  Patient has active ulcerative colitis	als valid for 6 months.		
			greater than or equal to 4	intolerable side effects or insufficient benefit to	
	and	or From prior therapy with immulation Patient has experienced into	nced an inadequate response to (including lack of ini nomodulators and corticosteroids lerable side effects from immunomodulators and cort costeroids are contraindicated		
Note:	Indic	cation marked with * is an unapproved in	dication.		
Curre	ent ap	- ulcerative colitis  proval Number (if known):  ns from any relevant practitioner. Approvites (tick boxes where appropriate)			
The SCCAI score has reduced by 2 points or more from the SCCAI score since initiation on biologic therapy  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:	Note: Indication marked with * is an unapproved indication.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 334 **Form SA2289** 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:	
Brentuximab			
Initial application — relapsed/refractory Hodgl Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)			
and	refractory CD30-positive Hodgkin lymphoma after two	o or more lines of chemotherapy	
Patient is ineligible fo	or autologous stem cell transplant		
Or Retient has released	refractory CD30-positive Hodgkin lymphoma	1	
and			
Patient has previous!	y undergone autologous stem cell transplant		
and Patient has not previously receive	ed funded brentuximab vedotin		
and		etment evelos	
and	treatment is to be reviewed after a maximum of 6 treatment is to be reviewed after a m		
Brentuximab vedotin to be admini	stered at doses no greater than 1.8 mg/kg every 3 we	eks	
Renewal — relapsed/refractory Hodgkin lympl	noma		
Current approval Number (if known):			
Applications from any relevant practitioner. Appro <b>Prerequisites</b> (tick boxes where appropriate)	vals valid for 9 months.		
Patient has achieved a partial or cand	complete response to brentuximab vedotin after 6 trea	ttment cycles	
Treatment remains clinically appro	opriate and the patient is benefitting from treatment ar	nd treatment is being tolerated	
Patient is to receive a maximum of	of 16 total cycles of brentuximab vedotin treatment		
Initial application — anaplastic large cell lymp Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)			
	D30-positive systemic anaplastic large cell lymphoma		
and Patient has an ECOG performance	ce status of 0-1		
and Patient has not previously receive			
and		ntment evelos	
and	treatment is to be reviewed after a maximum of 6 treatment is to be reviewed after a m		
Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 335 **Form SA2289** 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:			
Brentuximab - continued					
Renewal — anaplastic large cell lymphoma					
Current approval Number (if known):					
Applications from any relevant practitioner. Approvemental Prerequisites (tick boxes where appropriate)	rals valid for 9 months.				
Patient has achieved a partial or co	omplete response to brentuximab vedotin after 6 trea	tment cycles			
	Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated				
Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 336 **Form SA2293** June 2025

APPLICANT (stamp or sticker acceptable)		r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:
Name:				. Surname: Surname:	
Address:				DOB:	Address:
				Address:	
Fax Numbe	er:				Fax Number:
Trastuzu	ımab	(He	rzuma)		
Application	ns fron	n any	early breast cancer relevant practitioner. Appr xes where appropriate)	ovals valid for 15 months.	
	-	he p	atient has early breast can	cer expressing HER-2 IHC 3+ or ISH + (including FISH	or other current technology)
and		/laxin	num cumulative dose of 10	6 mg/kg (12 months' treatment)	
		-	east cancer*		
•	-		ber (if known):relevant practitioner. Appr	ovela valid for 12 months	
		-	xes where appropriate)	ovais valid for 12 months.	
	and		The patient has metastation	breast cancer expressing HER-2 IHC 3+ or ISH+ (incl	uding FISH or other current technology)
	and		The patient received prior	adjuvant trastuzumab treatment for early breast cancer	r
			The patient has not	previously received lapatinib treatment for HER-2 posit	ive metastatic breast cancer
	or				
	on lapatinib			ued lapatinib within 3 months due to intolerable side effects and the cancer did not progress whilst	
		0.	The cancer has not	rogressed at any time point during the previous 12 months whilst on trastuzumab	
	and				
		or	Trastuzumab will not	be given in combination with pertuzumab	
		01	Trastuzumab t	o be administered in combination with pertuzumab	
			least 12 montl	of received prior treatment for their metastatic disease and between prior (neo)adjuvant chemotherapy treatment	
			The patient ha	us good performance status (ECOG grade 0-1)	
	and		Trastuzumab to be discont	inued at disease progression	
or					
		Ш	Patient has previously disc disease progression	continued treatment with trastuzumab in the metastatic	setting for reasons other than severe toxicity or
	and		Patient has signs of diseas	se progression	
	and		-		
			Ulsease has not progresse	ed during previous treatment with trastuzumab	
Note: * Fo	lote: * For patients with relapsed HER-2 positive disease who have previously received adjuvant trastuzumab for early breast cancer				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 337 **Form SA2293** June 2025

APPLICANT (stamp or sticker acceptable)			PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:			Surname:	Surname:
Addre	ess:		DOB:	Address:
			Address:	
Fax N	lumbe	r:		Fax Number:
[ras	tuzuı	mab (Herzuma) - continued		
Appl	ication	lication — metastatic breast cancer as from any relevant practitioner. Approvites (tick boxes where appropriate)	rals valid for 12 months.	
	ا	The patient has metastatic breast	cancer expressing HER-2 IHC 3+ or ISH+ (including	FISH or other current technology)
	and	The patient has not previous	ly received lapatinib treatment for HER-2 positive me	etastatic breast cancer
		The patient discontinued lap lapatinib	atinib within 3 months due to intolerable side effects	and the cancer did not progress whilst on
	and			
		Trastuzumab will not be give	n in combination with pertuzumab	
			ministered in combination with pertuzumab	
	and		ved prior treatment for their metastatic disease and has had a treatment-free interval of at least	
		12 months between p	rior (neo)adjuvant chemotherapy treatment and diagn	
	The patient has good performance status (ECOG grade 0-1)			
	and			
		Trastuzumab to be discontinued at	disease progression	
Ren	ewal –	metastatic breast cancer		
Curr	ent ap	proval Number (if known):		
		ns from any relevant practitioner. Approvites (tick boxes where appropriate)	als valid for 12 months.	
	·			
The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other and		uding FISH or other current technology)		
		· · ·	sed at any time point during the previous 12 months v	vhilst on trastuzumab
		and Trastuzumab to be discontin	ued at disease progression	
or				
		Patient has previously disco	ntinued treatment with trastuzumab for reasons other	than severe toxicity or disease progression
		Patient has signs of disease	progression	
			during previous treatment with trastuzumab	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:		
Trastuzumab (Herzuma) - continued				
Initial application — gastric, gastro-oesophagea Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)  The patient has locally advanced of FISH+ or IHC3+ (or other current to and Patient has an ECOG score of 0-2	als valid for 12 months.  r metastatic gastric, gastro-oesophageal junction or o	pesophageal cancer expressing HER-2 IHC 2+		
Renewal — gastric, gastro-oesophageal junction and oesophageal cancer  Current approval Number (if known):				
The cancer has not progressed at a and  Trastuzumab to be discontinued at	any time point during the previous 12 months whilst o	on trastuzumab		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 339 **Form SA2420** June 2025

APPLICANT (stamp or sticker acceptable)		or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name	e:			Surname:	Surname:
Addre	ess:			DOB:	Address:
				Address:	
Fax N	lumbe	r:			Fax Number:
Tras	tuzur	mab der	ruxtecan		
Patient has metastatic breast cancer of and Patient has previously received trasturand The patient has received prior the patient developed disease and Patient has a good performance staturand		Patient has previously received.  The patient developed.  Patient has a good performation.	ith trastuzumab deruxtecan and met all remaining critical cancer expressing HER-2 IHC3+ or ISH+ (including yed trastuzumab and chemotherapy, separately or in yed prior therapy for metastatic disease disease recurrence during, or within six months of cance status (ECOG 0-1)	FISH or other current technology)	
	Renewal				
Appl	Current approval Number (if known):				
	and	_	cancer has not progressed at ment to be discontinued at di	any time point during the previous approval period w	hilst on trastuzumab deruxtecan
Noto	Note: Prior or adjuvant therapy includes anthropycline, other chametherapy, higherical drugs, or endearing therapy				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 340 **Form SA2453** 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:	
Bevacizumab			
Patient has locally advanced and Patient has preserved liver for Patient has not received funde or Patient received funde or Patient has an ECOG perform and To be given in combination or	ith bevacizumab, and met all remaining criteria prior to do r metastatic, unresectable hepatocellular carcinomounction (Child-Pugh A) ation (TACE) is unsuitable ed prior systemic therapy for the treatment of hepatoced lenvatinib before 1 March 2025 erienced treatment-limiting toxicity from treatment with gression since initiation of lenvatinib	a cellular carcinoma	
Renewal — unresectable hepatocellular carcin			
Current approval Number (if known):			
Prerequisites(tick box where appropriate)			
There is no evidence of disease progression			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 341 **Form SA2453** June 2025

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
Reg No:		First Names:	First Names:	
Name:		Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
Beva	umber:  cizumab - continued  I application — advanced or metastatic ov	arian cancer	Fax Number:	
	cations from any relevant practitioner. Approvequisites (tick boxes where appropriate)	als valid for 4 months.		
	The patient has FIGO Stage	IV epithelial ovarian, fallopian tube, or primary perito	neal cancer	
		ously untreated advanced (FIGO Stage IIIB or IIIC) ep	oithelial ovarian, fallopian tube, or primary	
	or Debulking surge	ery is inappropriate ub-optimally debulked (maximum diameter of any gro	ss residual disease greater than 1cm)	
	and			
	Bevacizumab to be administered a	t a maximum dose of 15 mg/kg every three weeks		
	18 weeks concurrent treatment wit	h chemotherapy is planned		
Renewal — advanced or metastatic ovarian cancer				
	ent approval Number (if known):			
	cations from any relevant practitioner. Approvequisites (tick box where appropriate)	als valid for 4 months.		
7	There is no evidence of disease progres	sion		
L				
Appli	I application — Recurrent Respiratory Parcations from any relevant practitioner. Approxequisites(tick boxes where appropriate)			
	Maximum of 6 doses			
	The patient has recurrent respirate	ry papillomatosis		
	The treatment is for intra-lesional a	administration		
	Renewal — Recurrent Respiratory Papillomatosis			
	ent approval Number (if known): cations from any relevant practitioner. Approv			
	equisites(tick boxes where appropriate)	rais valiu idi 12 monuis.		
	Maximum of 6 doses			
	The treatment is for intra-lesional a	administration		
		gical treatments or disease regrowth as a result of tre	atment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Bevacizumab - continued		
Initial application — Ocular Conditions Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)	vals valid without further renewal unless notified.	
Ocular neovascularisation		
Exudative ocular angiopathy		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 343 **Form SA2460** 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:Inotuzumab ozogamicin		Fax Number:
Prerequisites(tick boxes where appropriate)  Patient has relapsed or refractory Cand Patient has ECOG performance state  Patient has Philadelph  Patient has previously  or	ia chromosome positive B-Cell ALL received a tyrosine kinase inhibitor or line of treatment involving intensive chemotherapy	· · · · · · · · · · · · · · · · · · ·
Prerequisites (tick boxes where appropriate)  Patient is not proceeding to a stem  Patient has experienced com  Patient has experienced com	elevant practitioner on the recommendation of a rele	
and Treatment with inotuzumab ozogan	nicin is to cease after a total duration of 6 cycles	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Nivolumab		
Prerequisites (tick boxes where appropriate)  The individual has metastatic or unand Baseline measurement of overall tuand The individual has ECOG performation and The individual has not receive within 12 weeks of star and The cancer did not pro  and The individual has been diagor The individual did not receive or The individual did not received and The individual did not received and The individual did not expected and	resectable melanoma (excluding uveal) stage III or IV  umour burden is documented clinically and radiologic  unce 0-2	ally  dizumab and has discontinued pembrolizumab  V setting  D-L1 inhibitor  D-L1 inhibitor  th that PD-1/PD-L1 inhibitor

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Nivolumab - continued		
Current approval Number (if known):		ologic assessment following the most recent

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Nivolumab - continued		
Prerequisites(tick boxes where appropriate)  The individual has been on treatment and  The individual's or  The individual's or  The individual has and  Response to treatment the most recent treatment he most recent treatment progression  and  The individual has preprogression  and  The individual has signand	relevant practitioner on the recommendation of a relevant for more than 24 months  disease has had a complete response to treatment disease has had a partial response to treatment as stable disease	le radiologic or clinical assessment following

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		np or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Addres	ss:			DOB:	Address:
				Address:	
Nivolumab - continued					Fax Number:
Applic	cations	s from	<ul> <li>n — renal cell carcinoma, first any relevant practitioner. Appro k boxes where appropriate)</li> </ul>		
	or [	P	atient is currently on treatment w	vith nivolumab and met all remaining criteria prior to co	ommencing treatment
		and	The patient has metastatic	renal cell carcinoma	
		and	The patient is treatment nai	ve	
		[	The patient has ECOG perf	formance status 0-2	
		and	The disease is predominant	tly of clear cell histology	
		and	The patient has sarce	omatoid histology	
			or	ess than the lower limit of normal	
or Corrected serum calcium level greater than 10 mg/dL (2.5 mmol/L)					
			or  Neutrophils greater the	nan the upper limit of normal	
			or Platelets greater than	the upper limit of normal	
				year from original diagnosis to the start of systemic t	herapy
			Karnofsky performan	ce score of less than or equal to 70	
		and	Nivolumab is to be used in	combination with ipilimumab for the first four treatmen	it cycles at a maximum dose of 3 mg/kg
		and [	Nivolumab is to be used as	monotherapy at a maximum maintenance dose of 24	0 mg every 2 weeks (or equivalent)
Applic	cations	s from	<ul> <li>n — Renal cell carcinoma, sec any relevant practitioner. Appro k boxes where appropriate)</li> </ul>		
	and	P	atient has metastatic renal-cell c	earcinoma	
	The disease is of predominant clear-cell histology and Patient has ECOG performance status 0-2				
			atient has ECOG performance s	tatus 0-2	
	and	P	atient has documented disease	progression following one or two previous regimens o	f antiangiogenic therapy
	and	P	atient has not previously receive	d a funded immune checkpoint inhibitor	
	and [		livolumab is to be used as mono rogression	therapy at a maximum dose of 240 mg every 2 week	s (or equivalent) and discontinued at disease

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Nivolumab - continued					
, , ,	Current approval Number (if known):				
or	complete response to treatment partial response to treatment				
and  No evidence of disease progressic and  Nivolumab is to be used as monotl	n nerapy at a maximum dose of 240 mg every 2 week	s (or equivalent) and discontinued at disease			
progression					

#### SA2491 - Pembrolizumab

MSI-H/dMMR advanced colorectal cancer - Initial application	
MSI-H/dMMR advanced colorectal cancer - Renewal	361
Urothelial carcinoma - Initial application	361
Urothelial carcinoma - Renewal	
Breast cancer, advanced - Initial application	
Breast cancer, advanced - Renewal	
Head and neck squamous cell carcinoma - Initial application	
Head and neck squamous cell carcinoma - Renewal	
Non-small cell lung cancer first line combination therapy - Renewal	
Non-small cell lung cancer first line monotherapy - Renewal	
Non-small cell lung cancer first-line combination therapy - Initial application	
Non-small cell lung cancer first-line monotherapy - Initial application	
Relapsed/refractory Hodgkin lymphoma - Initial application	
Relapsed/refractory Hodgkin lymphoma - Renewal	
Stage III or IV resected melanoma - adjuvant - Initial application	
Stage III or IV resected melanoma - adjuvant - Innia application	
Stage III or IV resected melanoma - neoadjuvant - Initial application	
Unresectable or metastatic melanoma - Initial application	
the control of the co	
Unresectable or metastatic melanoma, less than 24 months on treatment - Renewal	
Unresectable or metastatic melanoma, more than 24 months on treatment - Renewal	354

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# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name	:			Surname:	Surname:
Addre	ss:			DOB:	Address:
				Address:	
Fax N	umbei	r:			Fax Number:
Peml	broli	zumab	- continued		
Appl	lication	ns only fro	- stage III or IV resected me m a relevant specialist or any oxes where appropriate)	elanoma - adjuvant y relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.
	or [	The i	ndividual is currently on treat	tment with pembrolizumab and met all remaining crite	ria prior to commencing treatment
				sected stage IIIB, IIIC, IIID or IV melanoma (excluding	g uveal) (see note a)
		or		has received neoadjuvant treatment with pembrolizum	nab
			and	nent with pembrolizumab is required	
			Adjuvani irealii	nerit with periorolizumab is required	
		and	The individual has not recei	ived prior funded systemic treatment in the adjuvant s	etting for stage IIIB, IIIC, IIID or IV melanoma
and Treatment must be in addition to complete surgical resection					
	and  Treatment must be initiated within 13 weeks of complete surgical resection, unless delay is necessary due to post-surgery		es delay is necessary due to post-surgery		
recovery (see note b)			within 10 weeks of complete surgical rescentifi, unless	as uclay is necessary due to post surgery	
		and	Pembrolizumab must be ad	Iministered as monotherapy	
			The individual has ECOG p	erformance score 0-2	
		and	Pembrolizumab to be admir	nistered at a fixed dose of 200 mg every 3 weeks (or $\epsilon$	equivalent)
Note	:				
a) S	tage II	IIB, IIIC, III	ID or IV melanoma defined a	s per American Joint Committee on Cancer (AJCC) 8	th Edition
			nt within 13 weeks of complete te of the resection (primary o	te surgical resection means 13 weeks after resection ( r lymphadenectomy)	(primary or lymphadenectomy) or 13 weeks prior to
Rene	ewal –	– stage III	or IV resected melanoma	- adjuvant	
Curre	ent ani	oroval Nur	mber (if known):		
Appli	cation	s only fron	,	relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.
	[ and	No ev	vidence of disease recurrenc	е	
	[	Pemb	orolizumab must be administ	ered as monotherapy	
	and [			d at a fixed dose of 200 mg every three weeks (or eq ystemic neoadjuvant treatment	uivalent) for a maximum of 12 months total
	and [			igns of disease recurrence or at completion of 12 mo ery 3 weeks), including any systemic neoadjuvant trea	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Pembrolizumab - continued		
Prerequisites(tick boxes where appropriate)  The individual has metastatic or use and Baseline measurement of overall and The individual has ECOG performand The individual has not received and The individual has not received and The individual has really weeks of starting and The cancer did not performand The individual has been did not performand The individual did not received and The individual received and		V cally mab and has discontinued nivolumab within V setting PD-L1 inhibitor
	t experience disease recurrence within six months of	completing perioperative treatment with a

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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Reg No: First Names: First Names:	
Name: Surname: Surname:	
Address: Address: Address:	
Address:	
Fax Number: Fax Number:	
Pembrolizumab - continued	
Renewal — unresectable or metastatic melanoma, less than 24 months on treatment	
Current approval Number (if known):	for 4 months.
Response to treatment in target lesions has been determined by comparable radiologic assessment following the treatment period  or	most recent
The individual has previously discontinued treatment with pembrolizumab for reasons other than severe toxicity o progression	r disease
The individual has signs of disease progression	
Disease has not progressed during previous treatment with pembrolizumab	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Pembrolizumab - continued		
Renewal — unresectable or metastatic melanor	ma, more than 24 months on treatment	
The individual has been on treatment and  The individual has been on treatment and  The individual's or  The individual has or  The individual has and  Response to treatment the most recent treatment he most recent treatment and  The individual has predisease progression and  The individual has signand	relevant practitioner on the recommendation of a relevant practitioner on the recommendation of a relevant for more than 24 months  disease has had a complete response to treatment disease has had a partial response to treatment as stable disease  t in target lesions has been determined by comparable	le radiologic or clinical assessment following or reasons other than severe toxicity or

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Pembrolizumab - continued		
and Patient has not had chemotherapy and Patient has not received prior functions and For patients with non-squamous hegfr or ALK tyrosine kinase unless and There is documentation convalidated test unless not post or There is documentation a validated test unless and Chemotherapy is determined.	notherapy  firming the disease expresses PD-L1 at a level great	er than or equal to 50% as determined by a greater than or equal to 1% as determined by
Patient has an ECOG 0-2  and  Pembrolizuman to be used at a m	aximum dose of 200 mg every three weeks (or equiva	alent) for a maximum of 16 weeks
and	numour burden is documented clinically and radiologic	,

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
	mab - continued		rax Nulliber.	
	non-small cell lung cancer first li	ine monotherapy		
Current appro	oval Number (if known):			
	only from a medical oncologist or a s(tick boxes where appropriate)	ny relevant practitioner on the recommendation of a me	edical oncologist. Approvals valid for 4 months.	
	Patient's disease has had	a complete response to treatment		
0		a partial response to treatment		
0				
and	1			
and	Response to treatment in target period	lesions has been determined by comparable radiologic	c assessment following the most recent treatment	
and	No evidence of disease progres	sion		
and	The treatment remains clinically	ppropriate and patient is benefitting from treatment		
and	Pembrolizumab to be used at a	aximum dose of 200 mg every three weeks (or equivalent)		
	Treatment with pembrolizumab 3 weeks)	to cease after a total duration of 24 months from comm	encement (or equivalent of 35 cycles dosed every	
Applications		cer first-line combination therapy any relevant practitioner on the recommendation of a m	edical oncologist. Approvals valid for 4 months.	
and	Patient has locally advanced or	metastatic, unresectable, non-small cell lung cancer		
and	The patient has not had chemot	herapy for their disease in the palliative setting		
and	Patient has not received prior fu	nded treatment with an immune checkpoint inhibitor for	NSCLC	
	For patients with non-squamous EGFR or ALK tyrosine kinase un	s histology there is documentation confirming that the d nless not possible to ascertain	isease does not express activating mutations of	
and	Pembrolizumab to be used in co	mbination with platinum-based chemotherapy		
and	Patient has an ECOG 0-2			
and	Pembrolizumab to be used at a	maximum dose of 200 mg every three weeks (or equiv	alent) for a maximum of 16 weeks	
and	Baseline measurement of overa	Il tumour burden is documented clinically and radiologic	cally	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:			First Names:	First Names:
Name:			Surname:	Surname:
Address:			DOB:	Address:
			Address:	
Fax Num	ber: .			Fax Number:
Pembr	olizu	mab - continued		
Renewa	al — n	on-small cell lung cancer first line	combination therapy	
Current	appro	val Number (if known):		
		nly from a medical oncologist or any (tick boxes where appropriate)	relevant practitioner on the recommendation of a me	edical oncologist. Approvals valid for 4 months.
Patient's disease has had a		· · · · · · · · · · · · · · · · · · ·	complete response to treatment	
		Patient's disease has had a	partial response to treatment	
	Patient has stable disease			
and  Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent period  and  No evidence of disease progression  and			assessment following the most recent treatment	
			n	
and Pembrolizumab to be used at a ma		The treatment remains clinically ap	propriate and patient is benefitting from treatment	
		Pembrolizumab to be used at a ma	aximum dose of 200 mg every three weeks (or equiva	alent)
Treatment with pembrolizumab to o			cease after a total duration of 24 months from comme	encement (or equivalent of 35 cycles dosed every

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPLICANT (stamp or sticker acceptable)		sticker acceptable)	PATIENT NHI:	REFERRER Reg No:		
Reg No:			First Names:	First Names:		
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbe	r:				Fax Number:
Pem	broli	zuma	<b>b</b> -	continued		
App	licatio	ns only ites(tick	fron k bo	xes where appropriate)	relevant practitioner on the recommendation of a rele	· · · · · · · · · · · · · · · · · · ·
or express ER, PR or HE		express ER, PR or HE  Patient has recurrent of	or de novo unresectable, inoperable locally advanced R2 IHC3+ or ISH+ [including FISH or other technology or de novo metastatic triple-negative breast cancer (the H or other technology])	gy])		
		and	_			
		and		Patient is treated with palliati	ve intent	
	Patient's cancer has confirmed PD-L1 Combine		ed PD-L1 Combined Positive Score (CPS) is greater	than or equal to 10		
	Patient has received no prior s		Patient has received no prior	systemic therapy in the palliative setting		
Patient has an ECOG score of		Patient has an ECOG score	of 0-2			
Pembrolizumab is to be used		Pembrolizumab is to be used	d in combination with chemotherapy			
and Baseline measurement of ov		Baseline measurement of ov	erall tumour burden is documented clinically and rad	iologically		
		and		Pembrolizumab is to be used	d at a maximum dose of 200 mg every three weeks (	or equivalent) for a maximum of 16 weeks

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:			
Pembrolizumab - continued					
Renewal — breast cancer, advanced					
Current approval Number (if known):					
Applications from any relevant practitioner. Approx	als valid for 6 months.				
Prerequisites(tick boxes where appropriate)					
Patient's disease has had a	complete response to treatment				
or Patient's disease has had a	partial response to treatment				
or Patient has stable disease					
and					
No evidence of disease progression	on				
Response to treatment in target lesions has been determined by a comparable radiologic assessment following the most recent					
and					
Pembrolizumab is to be used at a	Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent)  and				
Treatment with pembrolizumab is t every 3 weeks)	to cease after a total duration of 24 months from com	mencement (or equivalent of 35 cycles dosed			
Initial application — head and neck squamous Applications only from a relevant specialist or any	cell carcinoma relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.			
Prerequisites(tick boxes where appropriate)	·				
Patient is currently on treatment w	ith pembrolizumab and met all remaining criteria prior	r to commencing treatment			
carcinoma) that is incurable	astatic head and neck squamous cell carcinoma of m by local therapies	nucosal origin (excluding nasopharyngeal			
Patient has not received pric	or systemic therapy in the recurrent or metastatic setti	ing			
and Patient has a positive PD-L1	combined positive score (CPS) of greater than or ed	uual to 1			
and Patient has an ECOG perfor					
and	mance score of 0-2				
Pembrolizumab to be	used in combination with platinum-based chemothera	ару			
Pembrolizumab to be	used as monotherapy				
and Pembrolizumab is to be use	d at a maximum dose of 200 mg every three weeks (	or equivalent) for a maximum of 16 weeks			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:	
Pembrolizumab - continued			
Renewal — head and neck squamous cell card	inoma		
Current approval Number (if known):			
or Patient's disease has had a	complete response to treatment partial response to treatment		
Patient has stable disease			
and No evidence of disease progression and Pembrolizumab is to be used at a maximum dose of 200 mg every three weeks (or equivalent)			
and	to cease after a total duration of 24 months from com		
Initial application — MSI-H/dMMR advanced co Applications only from a relevant specialist or any Prerequisites(tick boxes where appropriate)	olorectal cancer relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.	
or Individual is currently on treatmen	t with pembrolizumab and met all remaining criteria pr	rior to commencing treatment	
Individual has deficien	nt mismatch repair (dMMR) or microsatellite instability	-high (MSI-H) metastatic colorectal cancer	
Individual has deficien	nt mismatch repair (dMMR) or microsatellite instability	-high (MSI-H) unresectable colorectal cancer	
and Individual is treated with pal	liative intent		
Individual has not previously	received funded treatment with pembrolizumab for N	4SI-H/dMMR advanced colorectal cancer	
Individual has an ECOG per	formance score of 0-2		
Baseline measurement of o	verall tumour burden is documented clinically and rad	iologically	
Pembrolizumab to be used	at a maximum dose of 200 mg every three weeks (or	equivalent) for a maximum of 16 weeks	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:
Pembrolizumab - continued		
Renewal — MSI-H/dMMR advanced colorectal c	ancer	
Current approval Number (if known):		
Applications from any relevant practitioner. Approv		
Prerequisites(tick boxes where appropriate)		
No evidence of disease progressio	n	
and Pembrolizumab to be used at a ma	eximum dose of 200 mg every three weeks (or equiva	alent)
and		·
every 3 weeks)	cease after a total duration of 24 months from com	mencement (or equivalent of 35 cycles dosed
Initial application — Urothelial carcinoma		
Applications only from a relevant specialist or any	relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)		
-	th pembrolizumab and met all remaining criteria prior	to commencing treatment
Patient has inoperable locall	y advanced (T4) or metastatic urothelial carcinoma	
and		
Patient has an ECOG perfor		
Patient has documented dise	ease progression following treatment with chemother	ару
Pembrolizumab to be used a	s monotherapy at a maximum dose of 200 mg every	three weeks (or equivalent) for a maximum of
Renewal — Urothelial carcinoma		
Current approval Number (if known):		
	relevant practitioner on the recommendation of a rele	vant specialist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)		
Patient's disease has had a	complete response to treatment	
or	partial response to treatment	
or	oarnai response to treatment	
Patient has stable disease		
No evidence of disease progressio	n	
and	ximum dose of 200 mg every three weeks (or equiva	elent)
and		·
every 3 weeks)	o cease after a total duration of 24 months from com	mencement (or equivalent of 35 cycles dosed

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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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:  Pembrolizumab - continued		Fax Number:
Prerequisites(tick boxes where appropriate)  Individual is currently on treatment or Individual has and	kin lymphoma y relevant practitioner on the recommendation of a rel  nt with pembrolizumab and met all remaining criteria p  relapsed/refractory Hodgkin lymphoma after two or m  eligible for autologous stem cell transplant	rior to commencing treatment
and Individual has not previous	ed/refractory Hodgkin lymphoma and has previously used/refractived funded pembrolizumab for relapsed/refractinistered at doses no greater than 200 mg once every	ory Hodgkin lymphoma
Renewal — relapsed/refractory Hodgkin lymp  Current approval Number (if known):  Applications only from a relevant specialist or any Prerequisites(tick boxes where appropriate)		evant specialist. Approvals valid for 6 months.
and	complete response to pembrolizumab to cease after a total duration of 24 months from com	mencement (or equivalent of 35 cycles dosed

I confirm the above details are correct and that in signing this form I understand I may be audited.

every 3 weeks)

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

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APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	o:	First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	SS:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Durv	alumab			
Appli	equisites(tick boxes where appropriate)  Patient has histologically or	r relevant practitioner on the recommendation of a rele cytologically documented stage III, locally advanced,		
	or (NSCLC)  Patient has histologically or cancer (NSCLC)	cytologically documented stage IIb (T1N2a only), loca	ally advanced, unresectable non-small cell lung	
	Patient has no disease progression therapy treatment  and Patient has a ECOG performance and Patient has completed last radiation and Patient must not have received print and Durvalumab is to be used a purvalumab is to be used a and and	or more cycles of platinum-based chemotherapy concurrently with definitive radiation therapy progression following the second or subsequent cycle of platinum-based chemotherapy with definitive radiation formance status of 0 or 1  set radiation dose within 8 weeks of starting treatment with durvalumab ceived prior PD-1 or PD-L1 inhibitor therapy for this condition  be used at a maximum dose of no greater than 10 mg/kg every 2 weeks  be used at a flat dose of 1500 mg every 4 weeks  ab to cease upon signs of disease progression		
Curre Appli	ewal — Non-small cell lung cancer ent approval Number (if known): cations only from a relevant specialist or any equisites(tick boxes where appropriate)	relevant practitioner on the recommendation of a rele	evant specialist. Approvals valid for 4 months.	
	The treatment remains clinically appropriate and the patient is benefitting from treatment			
	Durvalumab is to be used a	t a maximum dose of no greater than 10 mg/kg every	2 weeks	
	and  Treatment with durvalumab to cease upon signs of disease progression			
	Total continuous treatment duration must not exceed 12 months			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 364 **Form SA2443** 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:  Atezolizumab		Fax Number:
Patient has locally advanced or mand Patient has not received prior fundand For patients with non-squamous heggra or ALK tyrosine kinase unland Patient has an ECOG 0-2 and Patient has documented disease and Atezolizumab is to be used as monand	y relevant practitioner on the recommendation of a mediate and the recommendation of a mediate as a mediate and the recommendation of a mediate as a mediate as a mediate and the recommendation confirming that the distribution of the recommendation confirming that the distribution of the recommendation confirming that the distribution of the recommendation of a mediate and the recommendat	NSCLC sease does not express activating mutations of es of platinum-based chemotherapy or equivalent) for a maximum of 16 weeks
Renewal — non-small cell lung cancer second Current approval Number (if known): Applications only from a medical oncologist or any Prerequisites(tick boxes where appropriate)		edical oncologist. Approvals valid for 4 months.
or Patient's disease has had a or Patient has stable disease	a complete response to treatment	
and period  and No evidence of disease progressi  and	esions has been determined by comparable radiologic on ppropriate and patient is benefitting from treatment	assessment lonowing the most recent treatment
and	ximum dose of 1200 mg every three weeks (or equivalease after a total duration of 24 months from commen	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 365 **Form SA2443** 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:
Atezolizumab - continued		
Initial application — unresectable hepatocellular carcinoma Applications from any relevant practitioner. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)  Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment  Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma  Patient has preserved liver function (Child-Pugh A)  and  Transarterial chemoembolisation (TACE) is unsuitable  and  Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma  Patient received funded lenvatinib before 1 March 2025  Patient has experienced treatment-limiting toxicity from treatment with lenvatinib  No disease progression since initiation of lenvatinib  and  Patient has an ECOG performance status of 0-2  and  To be given in combination with bevacizumab		
Renewal — unresectable hepatocellular carcinoma		
Current approval Number (if known):		
Prerequisites (tick box where appropriate)		
There is no evidence of disease progress	sion	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 366 **Form SA2461** June 2025

eg No:		
eg IVO.	First Names:	First Names:
lame:	Surname:	Surname:
ddress:	DOB:	Address:
	Address:	
ax Number:		Fax Number:
pilimumab		
The patient has metastatic read and The patient is treatment naive and The patient has ECOG performs and The disease is predominantly and The patient has sarcor or Haemoglobin levels less or Corrected serum calcius or Neutrophils greater than tor Interval of less than 1 to or	ormance status 0-2 y of clear cell histology	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 367 **Form SA2455** 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:	
Tacrolimus			
Initial application — organ transplant Applications only from a relevant specialist. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)  The individual is an organ transplant recipient or The individual is receiving induction therapy for an organ transplant  Note: Subsidy applies for either primary or rescue therapy.			
Initial application — non-transplant indications Applications only from a relevant specialist. Appro Prerequisites(tick boxes where appropriate)			
Patient requires long-term systemic	cimmunosuppression		
	and discontinued treatment because of unacceptable	e side effects or inadequate clinical response	
Patient is a child with nephro	otic syndrome*		
Note: Indications marked with * are unapproved in	dications		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 368 **Form SA2270** June 2025

APPLICAN	IT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name:		Surname:	Surname:
Address:		DOB:	Address:
		Address:	
Fax Numbe	er:		Fax Number:
Sirolimu	s (Rapamune)		
		rals valid without further renewal unless notified.	
Note: Res	The drug is to be used for rescue therapy cue therapy defined as unresponsive to due to any of the following:	y for an organ transplant recipient calcineurin inhibitor treatment as defined by refractor	ry rejection; or intolerant to calcineurin inhibitor
• GFR<	30 ml/min; or		
Rapidly	y progressive transplant vasculopathy; or	r	
Rapidly	y progressive obstructive bronchiolitis; or	•	
• HUS o	r TTP; or		
• Leuko	encepthalopathy; or		
• Signific	cant malignant disease		
	olication — severe non-malignant lymns from any relevant practitioner. Approx		
	sites(tick boxes where appropriate)		
and	Patient has severe non-malignant	lymphovascular malformation*	
	Malformations are not adequor	uately controlled by sclerotherapy and surgery	
	I	ad/extensive and sclerotherapy and surgery are not o	considered clinically appropriate
	Sirolimus is to be used to re-	duce malformation prior to consideration of surgery	
and	Patient is being treated by a special	alist lymphovascular malformation multi-disciplinary to	eam
and		s defined by RECIST version 1.1 (see Note)	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 369 **Form SA2270** 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:
Sirolimus (Rapamune) - continued		
Renewal — severe non-malignant lymphovascu		
Current approval Number (if known):		
Prerequisites(tick boxes where appropriate)		
to RECIST version 1.1 (see Patient's disease has stabilis notes  and No evidence of progressive disease and The treatment remains clinically appropriate Note: Baseline assessment and disease response 1.1 (Eisenhauer et al. Eur J Cancer 2009;45:228-4	sed or responded clinically and disease response to the expropriate and the patient is benefitting from the treatment to be assessed according to the Response Evaluatory.	reatment has been clearly documents in patient
Indications marked with * are unapproved indicatio	ns	
Initial application — renal angiomyolipoma(s) a Applications only from a nephrologist or urologist.  Prerequisites(tick boxes where appropriate)		
Patient has tuberous sclerosis com and Evidence of renal angiomyolipoma	nplex* (s) measuring 3 cm or greater and that have shown in	nterval growth
Renewal — renal angiomyolipoma(s) associate	d with tuberous sclerosis complex*	
Current approval Number (if known):  Applications from any relevant practitioner. Approv  Prerequisites(tick boxes where appropriate)		
Documented evidence of renal and	giomyolipoma reduction or stability by magnetic reson	nance imaging (MRI) or ultrasound
Demonstrated stabilisation or impre	ovement in renal function	
	nced angiomyolipoma haemorrhage or significant adverse effects to sirolimus treatment	
	and the patient is benefitting from treatment	
Note: Indications marked with * are unapproved in	dications	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 370 **Form SA2270** 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:
Sirolimus (	Rapamune) - continued		
Applications	only from a neurologist. Approvals va s(tick boxes where appropriate)	ated with tuberous sclerosis complex* lid for 6 months.  ound of documented tuberous sclerosis complex	
c	Seizures are not adectreatment with at least phenytoin sodium, and  Vigabatrin is contrained and  Seizures are not adectreatment with at least	rialled and has not adequately controlled seizures puately controlled by, or the patient has experienced use two of the following: sodium valproate, topiramate, I diacosamide (see Note)  dicated  puately controlled by, or the patient has experienced use three of the following: sodium valproate, topiramate diacosamide (see Note)	evetiracetam, carbamazepine, lamotrigine,
and	Seizures have a significant impact	on quality of life	he patient has been assessed and would benefit
	of childbearing age potential are not to trial sodium valproate.	required to trial phenytoin sodium, sodium valproate,	or topiramate. Those who can father children are
Current appro		ulid for 12 months. improvement in seizure rate (e.g. 50% reduction in s	eizure frequency) or severity and/or patient quality
	fe compared with baseline prior to stations marked with * are unapproved in		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 371 **Form SA2414** 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:	
Everolimus			
Initial application Applications only from a neurologist or oncologist Prerequisites(tick boxes where appropriate)  Patient has tuberous sclerosis	. Approvals valid for 3 months.		
and	a sub apandumal giant call actrosytamas (SECAs) th	at require treatment	
Patient has progressively enlarging	g sub-ependymal giant cell astrocytomas (SEGAs) th	at require treatment	
Current approval Number (if known):			
Initial application — renal cell carcinoma Applications from any relevant practitioner. Appro Prerequisites(tick boxes where appropriate)	vals valid for 4 months.		
The patient has metastatic	renal cell carcinoma		
The disease is of predomin	ant clear-cell histology		
The patient has documente	d disease progression following one previous line of t	reatment	
The patient has an ECOG p	The patient has an ECOG performance status of 0-2		
Everolimus is to be used in combination with lenvatinib			
and Patient has experienced tre			
There is no evidence of dis	ease progression		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 372 **Form SA2414** 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:	
Everolimus - continued			
Renewal — renal cell carcinoma			
Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid for 4 months.  Prerequisites(tick box where appropriate)			
There is no evidence of disease progression			

#### SA2483 - Upadacitinib

Crohn's disease - adult - Initial application	
Crohn's disease - adult - Renewal	
Crohn's disease - children* - Initial application	
Crohn's disease - children* - Renewal	376
Rheumatoid Arthritis - Renewal	
Rheumatoid Arthritis (previously treated with adalimumab or etanercept) - Initial application	
Atopic dermatitis - Initial application	375
Atopic dermatitis - Renewal	375
Ulcerative colitis - Initial application	377
Ulcerative colitis - Renewal	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 374 **Form SA2483** 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:
Initial application — Rheumatoid Arthritis (prev Applications from any relevant practitioner. Approx Prerequisites(tick boxes where appropriate)  The individual has had an initial Sp and  The individual has experience or The individual has received in do not meet the renewal critic and  Rituximab is not clinically approx The individual is seronegative or The individual has been and The indiv	vals valid for 6 months.  pecial Authority approval for adalimumab and/or etangled intolerable side effects with adalimumab and/or ensufficient benefit from at least a three-month trial of eria for rheumatoid arthritis	adalimumab and/or etanercept such that they  odies and rheumatoid factor  ealth NZ Hospital
Renewal — Rheumatoid Arthritis		
or		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 375 **Form SA2483** June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	No:	First Names:	First Names:
Name	y:	Surname:	Surname:
Addre	ess:	DOB:	Address:
		Address:	
Fax N	lumber:		Fax Number:
Upac	dacitinib - continued		
App	al application — atopic dermatitis lications from any relevant practitioner. Appro equisites(tick boxes where appropriate)	vals valid for 6 months.	
	Individual is currently on treatment	with upadacitinib for atopic dermatitis and met all rer	maining criteria prior to commencing treatment
	Individual has moderate to s greater than or equal to 16 c and Individual has received insuf	evere atopic dermatitis, severity as defined by an Economic and Dermatology Life Quality Index (DLQI) score of grafficient benefit from topical therapy (including topical cast 6 months, unless contraindicated to all	reater than or equal to 10
	Individual has trialled and re ciclosporin, azathioprine, me	ceived insufficient benefit from at least one systemic ethotrexate or mycophenolate mofetil), unless contrain	ndicated to all
	while still on treatment but n	or DLQI assessment has been completed for at least the most recent prior treatment course, preferably but no longer than 1 month following cessation of each prior treatment course	
	The most recent EASI or DC	QLI assessment is no more than 1 month old at the tir	ne of application
D			
	ewal — atopic dermatitis		
Appli	ent approval Number (if known): ications from any relevant practitioner. Approv equisites(tick boxes where appropriate)		
	Individual has received a 75% or g	reater reduction in EASI score (EASI 75) as compare	ed to baseline EASI prior to commencing
	Individual has received a DLQI imp	provement of 4 or more as compared to baseline DLC	QI prior to commencing upadacitinib
App	al application — Crohn's disease - adult lications from any relevant practitioner. Appro equisites(tick boxes where appropriate)	vals valid for 6 months.	
	Individual is currently on treatment	with upadacitinib for Crohn's disease and met all ren	naining criteria prior to commencing treatment
	Individual has active Crohn's	s disease	
	Individual has had an benefit to meet renew.	initial approval for prior biologic therapy and has expe al criteria	erienced intolerable side effects or insufficient
	Individual meets	s the initiation criteria for prior biologic therapies for C	rohn's disease
	Other biologic th	nerapies for Crohn's disease are contraindicated	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 376 **Form SA2483** June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	:	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Upac	dacitinib - continued		
Rene	ewal — Crohn's disease - adult		
Curre	ent approval Number (if known):		
	cations from any relevant practitioner. Appro- equisites(tick boxes where appropriate)	vals valid for 2 years.	
		oints from the CDAI score when the individual was in	tiated on biologic therapy
		from when individual was initiated on biologic therap	py
	CDAI score is 150 or less		
	or  HBI score is 4 or less		
	or  The individual has experienced an	adequate response to treatment, but CDAI score car	anot be assessed
	The marriagar has experienced an		
App	al application — Crohn's disease - children lications from any relevant practitioner. Appro equisites(tick boxes where appropriate)		
	Individual is currently on treatment	t with upadacitinib for Crohn's disease and met all rer	naining criteria prior to commencing treatment
	Child has active Crohn's dis	ease	
		al approval for prior biologic therapy for Crohn's disea penefit to meet renewal criteria	se and has experienced intolerable side
		initiation criteria for prior biologic therapies for Crohr	n's disease
	and Other biologic t	herapies for Crohn's disease are contraindicated	
Rene	ewal — Crohn's disease - children*		
Curre	ent approval Number (if known):		
	cations from any relevant practitioner. Appro-	vals valid for 2 years.	
Prer	equisites(tick boxes where appropriate)		
	PCDAI score has reduced by 10 p	oints from the child was initiated on treatment	
	PCDAI score is 15 or less		
	The child has experienced an ade	quate response to treatment, but PCDAI score canno	t be assessed
Note	: Indications marked with * are unapproved ir	dications.	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 377 **Form SA2483** June 2025

APPL	ICAN	T (sta	mp or	sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	o:				First Names:	First Names:
Name	:				Surname:	Surname:
Addre	ss:				DOB:	Address:
					Address:	
Fax N	umbe	er:				Fax Number:
Upad	lacit	inib	- con	tinued		
Appl	icatio	ns fro	m any	Individual has active ulcera  Individual has had ar effects or insufficient  Individual meet	it with upadacitinib for ulcerative colitis and met all rer	e colitis and has experienced intolerable side
Rene	wal -	– ulc	erativ	e colitis		
Appli	catior	ns fror	n any	ber (if known):relevant practitioner. Approxes where appropriate)		
	05		The S	CCAI score has reduced by	2 points or more from the SCCAI score when the ind	ividual was initiated on treatment
	or		PUCA	I score has reduced by 10 p	points or more from the PUCAI score when the individ	ual was initiated on treatment

**Respiratory System and Allergies** 

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 379 **Form SA2185** 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:
Adrenaline		
Initial application — anaphylaxis Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	als valid without further renewal unless notified.	7
Patient has experienced an a	anaphylactic reaction which has resulted in presentat	ion to a hospital or emergency department
	o be at significant risk of anaphylaxis by a relevant pr	ractitioner
and Patient is not to be prescribed more	e than two devices in initial prescription	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 380 **Form SA1558** 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:	
Icatibant			
Initial application Applications only from a clinical immunologist or relevant specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Supply for anticipated emergency treatment of laryngeal/oro-pharyngeal or severe abdominal attacks of acute hereditary angioedema (HAE) for patients with confirmed diagnosis of C1-esterase inhibitor deficiency  The patient has undergone product training and has agreed upon an action plan for self-administration			
Renewal  Current approval Number (if known):			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 381 **Form SA1367** 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:
Bee or wasp venom allergy treatment		
Initial application Applications only from a relevant specialist. Appro Prerequisites(tick boxes where appropriate)  RAST or skin test positive and Patient has had severe generalised	, 	
Renewal  Current approval Number (if known):  Applications only from a relevant specialist. Appro Prerequisites(tick box where appropriate)	vals valid for 2 years.	
The treatment remains appropriate and t	he patient is benefiting from treatment	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 382 Form SA1584 June 2025

APPLI	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	0:	First Names:	First Names:
Name:		Surname:	Surname:
Addres	SS:	DOB:	Address:
		Address:	
Fax Nu	umber:		Fax Number:
Long	-Acting Muscarinic Antagonists w	rith Long-Acting Beta-Adrenoceptor Ag	onists
Applic	application cations from any relevant practitioner. Approvequisites(tick boxes where appropriate)  Patient has been stabilised on a loand  The prescriber considers that the prescriber considers the prescriber considers that the prescriber considers the prescriber co		g to a combination product
Rene	wal nt approval Number (if known):		
	cations from any relevant practitioner. Approv		
	equisites(tick boxes where appropriate)	als valid for 2 years.	
	Patient is compliant with the medic	ation	
		COPD symptom control (prescriber determined)	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 383 **Form SA2326** 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:
Fluticasone furoate with umeclidinium	and vilanterol	
possible  Patient is currently recemuscarinic antagonist of the muscarinic	eiving an inhaled corticosteroid with long acting beta- with long acting beta-2 agonist (LAMA/LABA)  DPD Assessment Test (CAT) score greater than 10 2 or more exacerbations in the previous 12 months one exacerbation requiring hospitalisation in the previous an eosinophil count greater than or equal to 0.3 × 10  multiple inhaler triple therapy (inhaled corticosteroid LAMA/LABA) and met at least one of the clinical crite	2 agonist (ICS/LABA) or a long acting rious 12 months  ^9 cells/L in the previous 12 months  with long acting muscarinic antagonist and long

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 384 Form SA2421 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:
Budesonide with glycopyrronium and e	eformoterol	
possible  Patient is currently recommuscarinic antagonist  Clinical criteria: Patient has a CCO  or Patient has had  or Patient has had  or Patient has had  or Patient has had	eiving an inhaled corticosteroid with long acting beta with long acting beta-2 agonist (LAMA/LABA)  DPD Assessment Test (CAT) score greater than 10  2 or more exacerbations in the previous 12 months one exacerbation requiring hospitalisation in the previous an eosinophil count greater than or equal to 0.3 × 10  multiple inhaler triple therapy (inhaled corticosteroid	2 agonist (ICS/LABA) or a long acting vious 12 months  9 cells/L in the previous 12 months
	ICS/LAMA/LABA) and met at least one of the clinica	

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 385 Form **SA2013** 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:
Pirfenidone		
and Forced vital capacity is between 50 and Pirfenidone is to be discontinued at and Pirfenidone is not to be used in con and The patient has not previousl or Patient has previously receive more decline in predicted FV6	iopathic pulmonary fibrosis by a multidisciplinary tea % and 90% predicted	weeks due to intolerance ressed (disease progression defined as 10% or
and	rovals valid for 12 months.  Priate and patient is benefitting from and tolerating tree	eatment

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 386 Form **SA2012** 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:	
Nintedanib			
Initial application — idiopathic pulmonary fibrosis Applications only from a respiratory specialist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist  and Patient has been diagnosed with idiopathic pulmonary fibrosis by a multidisciplinary team including a radiologist  Forced vital capacity is between 50% and 90% predicted  and Nintedanib is to be discontinued at disease progression (See Note)  and Nintedanib is not to be used in combination with subsidised pirfenidone  and Patient has not previously received treatment with pirfenidone  or Patient has previously received pirfenidone, but discontinued pirfenidone within 12 weeks due to intolerance  Patient has previously received pirfenidone, but the patient's disease has not progressed (disease progression defined as 10% or more decline in predicted FVC within any 12 month period since starting treatment with pirfenidone)			
Renewal — idiopathic pulmonary fibrosis  Current approval Number (if known):			
Treatment remains clinically appro	priate and patient is benefitting from and tolerating tre	eatment	
Nintedanib is to be discontinued at	disease progression (See Note)		

Note: disease progression is defined as a decline in percent predicted FVC of 10% or more within any 12 month period.

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 387 **Form SA1978** 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:	
Dornase Alfa			
Initial application — cystic fibrosis Applications only from a respiratory physician or paediatrician. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Patient has a confirmed diagnosis of cystic fibrosis and Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline and Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period or Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period or Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of  22/25 Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)			
Renewal — cystic fibrosis			
Current approval Number (if known):			
The treatment remains appropriate and the patient continues to benefit from treatment			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 388 **Form SA2017** June 2025

REFERRER Reg No:
First Names:
Surname:
Address:
Fax Number:
conductance regulator (CFTR) gene on at least 1 allele 178R, G551S, S1251N, S1255P, S549N and S549R) in e pilocarpine iontophoresis or by Macroduct sweat this condition exacerbation, or changes in therapy (including antibiotics) vacaftor

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 389 **Form SA2456** 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:  Elexacaftor with tezacaftor, ivacaftor a	nd ivacaftor	Fax Number:	
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick boxes where appropriate)	rals valid without further renewal unless notified.		
Patient has been diagnosed with cystic fibrosis  and Patient is 6 years of age or older  and			
or parental allele)	s-causing mutations in the cystic fibrosis transmember value of at least 60 mmol/L by quantitative pilocarping		
and  Patient has a heterozygous or homozygous F508del mutation  or  Patient has a G551D mutation or other mutation responsive in vitro to elexacaftor/tezacaftor/ivacaftor (see note a)			
and	nded CFTR modulator therapy for this condition tor/ivacaftor must be given concomitantly with standa	ard therapy for this condition	
Note:			
<ul> <li>Eligible mutations are listed in the Food and Drug Administration (FDA) Trikafta prescribing information <a href="https://nctr-crs.fda.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc">https://nctr-crs.fda.gov/fdalabel/services/spl/set-ids/f354423a-85c2-41c3-a9db-0f3aee135d8d/spl-doc</a></li> </ul>			

#### **Sensory Organs**

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 391 Form SA1680 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:	
Dexamethasone 700 mcg ocular impl	ants		
Initial application — Diabetic macular oedema Applications only from an ophthalmologist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Patient has diabetic macular oedema with pseudophakic lens and Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision and Patient's disease has progressed despite 3 injections with bevacizumab or Patient is unsuitable or contraindicated to treatment with anti-VEGF agents and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year			
Renewal — Diabetic macular oedema  Current approval Number (if known):			
Initial application — Women of child bearing age with diabetic macular oedema Applications only from an ophthalmologist. Approvals valid for 12 months.  Prerequisites(tick boxes where appropriate)  Patient has diabetic macular oedema  and Patient has reduced visual acuity of between 6/9 - 6/48 with functional awareness of reduction in vision  and Patient is of child bearing potential and has not yet completed a family  and Dexamethasone implants are to be administered not more frequently than once every 4 months into each eye, and up to a maximum of 3 implants per eye per year			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 392 Form SA1680 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:		
Dexamethasone 700 mcg ocular impla	nts - continued			
Renewal — Women of child bearing age with diabetic macular oedema				
Current approval Number (if known):				
Applications only from an ophthalmologist. Approv	als valid for 12 months.			
Prerequisites(tick boxes where appropriate)				
Patient's vision is stable or has imp	proved (prescriber determined)			
Patient is of child bearing potential	and has not yet completed a family			
	administered not more frequently than once every 4	months into each eye, and up to a maximum of		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 393 **Form SA1715** 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:	
Prednisolone sodium phosphate			
Initial application Applications only from an ophthalmologist or optometrist. Approvals valid for 6 months.  Prerequisites(tick boxes where appropriate)			
Patient has severe inflammation			
Patient has a confirmed allergic reaction to preservative in eye drops			
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick box where appropriate)	rals valid for 6 months.		
The treatment remains appropriate and t	ne patient is benefiting from treatment		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 394 Form SA0895 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:	
or Patient wears soft contact lenses		al authority items.	
Renewal			
Current approval Number (if known):			
Applications from any relevant practitioner. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)			
The treatment remains appropriate and the	ne patient is benefiting from treatment		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 395 **Form SA2431** June 2025

APPLICANT (stamp or sticker acceptable)		or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:			First Names:	First Names:	
Name:			Surname:	Surname:	
Address:			DOB:	Address:	
				Address:	
Fax N	umber	:			Fax Number:
Preservative Free Ocular Lubricants					
Initial application Applications from any relevant practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick boxes where appropriate)					
Confirmed diagnosis by slit lamp or Schirmer test of severe secretory dry eye					
		Patient is using eye drops more than four times daily on a regular basis			
		or	Patient has had a confirmed	allergic reaction to preservative in eye drop	

#### **Various**

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 397 Form SA1480 June 2025

APPL	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	0:	First Names:	First Names:
Name:		Surname:	Surname:
Addres	SS:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Deferiprone			
Applic	application cations only from a haematologist. Approvals quisites(tick boxes where appropriate)	valid without further renewal unless notified.	
	<u> </u>	ith chronic iron overload due to congenital inherited a	anaemia
	The patient has been diagnosed w	rith chronic iron overload due to acquired red cell apla	asia

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 398 **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		
and  Deferasirox is to be given at a daily and  Treatment with maximum tole have proven ineffective as m  Treatment with deferiprone h  or  Treatment with deferiprone is	ith chronic iron overload due to congenital inherited at dose not exceeding 40 mg/kg/day erated doses of deferiprone monotherapy or deferiprone assured by serum ferritin levels, liver or cardiac MRI as resulted in severe persistent vomiting or diarrhoed	one and desferrioxamine combination therapy T2* a (defined as an absolute neutrophil count (ANC)
parameters namely serum ferritin, o	valid for 2 years.  ars of therapy, the treatment has been tolerated and cardiac MRI T2* and liver MRI T2* levels	
	ment has been tolerated and has resulted in clinical cardiac MRI T2* and liver MRI T2* levels	stability or continued improvement in all three

#### **Special Foods**

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 400 Form SA1930 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	lo:	First Names:	First Names:
Name	:	Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Carb	ohydrate (Moducal; Polycal)		
Appli	al application — Cystic fibrosis or kidney dications only from a dietitian, relevant specialisequisites(tick boxes where appropriate)  Cystic fibrosis  Chronic kidney disease	isease st or vocationally registered general practitioner. App	rovals valid for 3 years.
Appli	al application — Indications other than cys cations only from a dietitian, relevant specialis equisites(tick boxes where appropriate)	tic fibrosis or renal failure st or vocationally registered general practitioner. App	rovals valid for 1 year.
Initia Appli	or Faltering growth in an infant/child or Bronchopulmonary dysplasia or Premature and post premature infa or For use as a component in a modu D of the Pharmaceutical Schedule Patients are required to meet any Special All application — Inborn errors of metabolis	ular formula made from at least one nutrient module a or breast milk uthority criteria associated with all of the products use m st or vocationally registered general practitioner. App	and at least one further product listed in Section ed in the modular formula.
Rene	ewal — Cystic fibrosis or renal failure		
Appli dietit		st, vocationally registered general practitioner or gene ad general practitioner. Approvals valid for 3 years.	eral practitioner on the recommendation of a
	The treatment remains appropriate	and the patient is benefiting from treatment	
	and	ame of the dietitian, relevant specialist or vocationall	y registered general practitioner and date

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 401 Form SA1930 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:		
Carbohydrate (Moducal; Polycal) - continued				
Renewal — Indications other than cystic fibrosi	is or renal failure			
Current approval Number (if known):				
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.				
Prerequisites(tick box, and write the data requested in the space provided where appropriate)				
The treatment remains appropriate and the patient is benefiting from treatment  and  General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 402 **Form SA1376** 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:  Carbohydrate and Fat (Duocal Super Soluble		Fax Number:
Initial application — Cystic fibrosis	ist or vocationally registered general practitioner. App	rovals valid for 3 years.
_ '		
Initial application — Indications other than cys Applications only from a dietitian, relevant speciali Prerequisites(tick boxes where appropriate)	stic fibrosis ist or vocationally registered general practitioner. App	rovals valid for 1 year.
Infant or child aged four years or u	under	
Cancer in children  or  Faltering growth		
or  Bronchopulmonary dysplasi  or  Premature and post premat		
Renewal — Cystic fibrosis		
	ist, vocationally registered general practitioner or general general practitioner. Approvals valid for 3 years.	eral practitioner on the recommendation of a
The treatment remains appropriate	e and the patient is benefiting from treatment	
	name of the dietitian, relevant specialist or vocationall	
Renewal — Indications other than cystic fibros	sis	
	ist, vocationally registered general practitioner or general general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
The treatment remains appropriate	e and the patient is benefiting from treatment	
	name of the dietitian, relevant specialist or vocationall	, ,

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 403 **Form SA2204** 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:
Fat (Calogen; Liquigen; MCT oil (Nutricia))  Initial application — Inborn errors of metabolis Applications only from a dietitian, relevant specialis Prerequisites(tick box where appropriate)  The patient has an inborn error of metabolis	st or vocationally registered general practitioner. App	rovals valid without further renewal unless notified.
Initial application — Indications other than inbedeplications only from a dietitian, relevant specialist Prerequisites (tick boxes where appropriate)	orn errors of metabolism st or vocationally registered general practitioner. App	rovals valid for 1 year.
D of the Pharmaceutical Schedule	ular formula made from at least one nutrient module a	·
Renewal — Indications other than inborn error Current approval Number (if known):	st, vocationally registered general practitioner or general general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
and General Practitioners must include the r	e and the patient is benefiting from treatment name of the dietitian, relevant specialist or vocationally	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 404 Form SA1524 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:	
Protein (Protifar; Promod; Resource Beneprotein)			
Prerequisites (tick boxes where appropriate)  Protein losing enteropathy  or  High protein needs  or  For use as a component in a modu  D of the Pharmaceutical Schedule	t or vocationally registered general practitioner. App  lar formula made from at least one nutrient module a  or breast milk  uthority criteria associated with all of the products use	and at least one further product listed in Section	
Renewal			
Current approval Number (if known):			
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  Prerequisites(tick box, and write the data requested in the space provided where appropriate)			
and General Practitioners must include the na	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally	, ,	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 405 Form SA1095 June 2025

APPL	CANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	0:	First Names:	First Names:	
Name		Surname:	Surname:	
Addre	SS:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Diab	etic products (Diason RTH; Glucerna Sel	ect RTH; Diasip; Glucerna Select; Resource Diabetic	)	
Appli	Initial application Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  Prerequisites(tick box where appropriate)  The patient is a type I or and II diabetic who is suffering weight loss and malnutrition that requires nutritional support			
Renewal  Current approval Number (if known):				
	and General Practitioners must include the n	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally		

#### APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 406 **Form SA2205** 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:		
Initial application — Inborn errors of metabolism Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)  The patient has an inborn error of metabolism				
Initial application — Indications other than errors of inborn metabolism Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  Prerequisites(tick boxes where appropriate)				
Patient has a chyle leak  or  Modified as a modular feed, made from at least one nutrient module and at least one further product listed in Section D of the Pharmaceut Schedule, for adults				
Note: Patients are required to meet any Special A	uthority criteria associated with all of the products use	ed in the modular formula.		
Renewal  Current approval Number (if known):				
The treatment remains appropriate and the patient is benefiting from treatment  and  General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 407 Form SA1098 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg N	0:	First Names:	First Names:	
Name	·	Surname:	Surname:	
Addre	ss:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Paed	iatric Product For Children Awaiti	ng Liver Transplant (Heparon Junior)		
Appli	Initial application Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.  Prerequisites(tick box where appropriate)  The patient is a child (up to 18 years) who requires a liver transplant			
Renewal  Current approval Number (if known):				
Appli dietit	Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.  Prerequisites(tick box, and write the data requested in the space provided where appropriate)			
	and	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally	y registered general practitioner and date	
	contacted			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 408 Form SA1099 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:	
Paediatric Product For Children With C	Chronic Renal Failure (Kindergen)		
Initial application Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years.  Prerequisites (tick box where appropriate)			
The patient is a child (up to 18 years) with acute or chronic kidney disease			
Renewal			
Current approval Number (if known):			
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 3 years. <b>Prerequisites</b> (tick box, and write the data requested in the space provided where appropriate)			
	The treatment remains appropriate and the patient is benefiting from treatment		
	ame of the dietitian, relevant specialist or vocationally		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 409 **Form SA1379** June 2025

APPLICANT (stamp or sticker acceptable)		PATIENT NHI:	REFERRER Reg No:	
Reg No:		First Names:	First Names:	
Name	:	Surname:	Surname:	
Addre	SS:	DOB:	Address:	
		Address:		
Fax N	umber:		Fax Number:	
Paed	iatric Products			
Prerequisites(tick boxes where appropriate)  Child is aged one to ten years  and  The child is being fed via a t  or  Any condition causing malab  or  Faltering growth in an infant/  or  Increased nutritional require  or		child	·	
	Renewal			
Current approval Number (if known):		eral practitioner on the recommendation of a		
dietitian, relevant specialist or vocationally registere			yran praesition on the recommendation of a	
Trerequisites (non box, and write the data requeste		od in the space provided where appropriate)		
	The treatment remains appropriate	and the patient is benefiting from treatment		
	General Practitioners must include the n	ame of the dietitian, relevant specialist or vocational	, ,	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 410 **Form SA1101** 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:
Renal Products (Nepro; NovaSource Renal; Re	enilon 7.5; Suplena)	
Initial application Applications only from a dietitian, relevant specialis Prerequisites(tick box where appropriate)  The patient has acute or chronic kidney of	st or vocationally registered general practitioner. App	rovals valid for 3 years.
Renewal		
Current approval Number (if known):		
Applications only from a dietitian, relevant specialist dietitian, relevant specialist or vocationally registered	st, vocationally registered general practitioner or general general practitioner. Approvals valid for 3 years.	eral practitioner on the recommendation of a
Prerequisites(tick box, and write the data requested	ed in the space provided where appropriate)	
and General Practitioners must include the n	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocational	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 411 Form SA1377 June 2025

APPL	LICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name	):	Surname:	Surname:
Addre	ess:	DOB:	Address:
		Address:	
Fax N	lumber:		Fax Number:
Spec	cialised And Elemental Products		
Appl Pren	equisites(tick boxes where appropriate)  Malabsorption or Short bowel syndrome or Enterocutaneous fistulas or Eosinophilic oesophagitis or Inflammatory bowel disease or Patients with multiple food allergie : Each of these products is highly specialised	st or vocationally registered general practitioner. App s requiring enteral feeding and would be prescribed only by an expert for a sper	cific disorder. The alternative is hospitalisation.
Appl dietit	ent approval Number (if known):ications only from a dietitian, relevant speciali	st, vocationally registered general practitioner or gene ed general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
	and General Practitioners must include the r	e and the patient is benefiting from treatment name of the dietitian, relevant specialist or vocational	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 412 Form SA1196 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:
Paediatric enteral feed with fibre 0.75 k	ccal/ml (Nutrini Low Energy Multi Fibre)	
Prerequisites(tick boxes where appropriate)  Child aged one to eight years and	st or vocationally registered general practitioner. App	·
Renewal		
Current approval Number (if known):	st, vocationally registered general practitioner or gene ed general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
and General Practitioners must include the n	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally	, 5

#### SA1859 - Standard Supplements

Adults - Initial application	
Children - exclusive enteral nutrition for Crohn's disease - Initial application	
Children - exclusive enteral nutrition for Crohn's disease - Renewal	41
Children - indications other than exclusive enteral nutrition for Crohn's disease - Initial application	41
Children - indications other than exclusive enteral nutrition for Crohn's disease - Renewal	41
Chronic disease OR tube feeding for patients who have previously been funded under Special Auth	ority form
SA0702 or SA0583 - Renewal	41
ong-term medical condition - Initial application	41
Short-term medical condition - Initial application	
Short-term medical condition - Renewal	41

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 414 Form SA1859 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:	
Standard Supplements			
Initial application — Children - indications other than exclusive enteral nutrition for Crohn's disease Applications from any relevant practitioner. Approvals valid for 1 year.  Prerequisites(tick boxes where appropriate)  The patient is under 18 years of age  and  The patient has a condition causing malabsorption  or  The patient has failure to thrive  or  The patient has increased nutritional requirements  and  Nutrition goal has been set (eg reach a specific weight or BMI)			
Renewal — Children - indications other than exclusive enteral nutrition for Crohn's disease			
Current approval Number (if known):			
Applications from any relevant practitioner. Approx <b>Prerequisites</b> (tick boxes where appropriate)	als valid for 1 year.		
Troisquestes (teleposes misro appropriate)			
The patient is under 18 years of ac	ge		
The treatment remains appropriate	and the patient is benefiting from treatment		
A nutrition goal has been set (eg re	each a specific weight or BMI)		
Initial application — Children - exclusive enteral nutrition for Crohn's disease			
	itian on the recommendation of a gastroenterologist.	Approvals valid for 3 months.	
The patient is under 18 years of ac	ge		
	I nutrition for the treatment of Crohn's disease		
	f the gastroenterologist recommending treatment and	d the date the gastroenterologist was contacted	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 415 **Form SA1859** June 2025

APPLICAN	(stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:		First Names:	First Names:
Name:		Surname:	Surname:
Address:		DOB:	Address:
		Address:	
	······································		Fax Number:
Standard	Supplements - continued		
Renewal –	- Children - exclusive enteral nutrition	on for Crohn's disease	
Current app	proval Number (if known):		
	•	recommendation of a gastroenterologist. Approvals vested in the space provided where appropriate)	valid for 3 months.
was		al nutrition for the treatment of Crohn's disease st include the name of the gastroenterologist recomm	ending treatment and the date the gastroenterologis
	ns from any relevant practitioner. Appro tes(tick boxes where appropriate)	ovals valid for 3 months.	
	Patient is Malnourished		
		dex (BMI) of less than 18.5 kg/m²	
	Patient has unintentional we	eight loss greater than 10% within the last 3-6 months	; 
		an 20 kg/m <sup>2</sup> and unintentional weight loss greater tha	ın 5% within the last 3-6 months
and	Detions has not responded to fi	wat line distant managemen even a 4 week maried by	
		rst-line dietary measures over a 4 week period by frequency (eg snacks between meals)	.
	or Using high-energy foods (e.	g. milkshakes, full fat milk, butter, cream, cheese, su	igar etc)
	Using over the counter supp	plements (e.g. Complan)	
and [	A nutrition goal has been set (e.g.	to reach a specific weight or BMI)	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 416 Form SA1859 June 2025

APPLICANT (s	tamp 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:
Renewal — A	dults val Number (if known):		
	om any relevant practitioner. Appro (tick boxes where appropriate)	vals valid for 6 months.	
and	A nutrition goal has been set (eg r	each a specific weight or BMI)	
Patient has a body mass index (BMI) of less than 18.5 kg/m <sup>2</sup>			
Patient has unintentional weight loss greater than 10% within the last 3-6 months  or			
	Patient has a BMI of less the	an 20 kg/m <sup>2</sup> and unintentional weight loss greater tha	nn 5% within the last 3-6 months
Applications fr	tion — Short-term medical condition any relevant practitioner. Appro		
or	Is being fed via a nasogastric tube	e or a nasogastric tube is to be inserted for feeding	
	Malignancy and is considered like	ly to develop malnutrition as a result	
or	Is undergoing a bone marrow tran	splant	
or	Tempomandibular surgery or glos	sectomy	
or	Pregnant		
	Patient is in early pre	gnancy (< 13 weeks) and has severe clinical hyperer y to meet her nutritional requirements due to continui	
	unlikely to meet the Ir	peremesis gravidarum continuing past 13 weeks and nstitute of Medicine's (1990) recommended weight ga sed past her booking/pre-pregnancy weight	d either there is concern that the patient is in guidelines for pregnancy or the patient's
		iple births and is under the care of an obstetric team met	who consider the nutritional needs of the
		·	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 417 **Form SA1859** 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:
Standard Supplements - continued		
or Has undergone a bone marrow tractor  Tempomandibular surgery or gloss or  Pregnant  and  Patient is in early pregnant is unlikely or  Patient has clinical hy unlikely to meet the In weight has not increase	y to develop malnutrition as a result  nsplant  grancy (< 13 weeks) and has severe clinical hyperen y to meet her nutritional requirements due to continuir peremesis gravidarum continuing past 13 weeks and stitute of Medicine's (1990) recommended weight gai sed past her booking/pre-pregnancy weight ple births and is under the care of an obstetric team y	either there is concern that the patient is n guidelines for pregnancy or the patient's

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 418 **Form SA1859** 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:
Standard Supplements - continued		
Prerequisites(tick boxes where appropriate)	rovals valid without further renewal unless notified.	astric tube - refer to specific medical condition
Chronic obstructive pulmonary d	isease with hypercapnia	
Short bowel syndrome		
or Bowel fistula		
or Severe chronic neurological cond	ditions	
Epidermolysis bullosa		
AIDS (CD4 count < 200 cells/mn	n³)	
Chronic pancreatitis		

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 419 **Form SA1859** June 2025

APPLI	CAN	<b>VT</b> (st	amp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No	o:			First Names:	First Names:
Name:				Surname:	Surname:
Addres	s: .			DOB:	Address:
				Address:	
Fax Nu	mbe	er:			Fax Number:
Stand	lard	d Su	pplements - continued		
Renev	wal	— CI	nronic disease OR tube feeding fo	r patients who have previously been funded und	er Special Authority forms SA0702 or SA0583
Applic Prerec	atio	ns fro	tick boxes where appropriate)	als valid without further renewal unless notified.  to be inserted for the purpose of feeding (not nasoga	stric tube - refer to specific medical condition
Chronic obstructive pulmonary disease with hypercapnia			Chronic obstructive pulmonary dise	ease with hypercapnia	
	or	Ш	Short bowel syndrome		
			Bowel fistula		
	or		Severe chronic neurological conditi	ons	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 420 **Form SA1195** 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:			
High Calorie Products (Two Cal HN; Nutrisc	on Concentrated)				
Initial application — Cystic fibrosis Applications only from a dietitian, relevant speciali Prerequisites(tick boxes where appropriate)  Cystic fibrosis	ist or vocationally registered general practitioner. Арр	provals valid for 3 years.			
and Other lower calorie products have	and Other lower calorie products have been tried				
Initial application — Indications other than cystic fibrosis Applications only from a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  Prerequisites(tick boxes where appropriate)  Any condition causing malabsorption or					
dietitian, relevant specialist or vocationally register  Prerequisites(tick box, and write the data reques  The treatment remains appropriate and	ist, vocationally registered general practitioner or gen red general practitioner. Approvals valid for 3 years.				
contacted	name of the dictition, relevant specialist of vocational	iy registered general practitioner and date			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 421 Form SA1195 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:	
High Calorie Products (Two Cal HN; Nutrison	n Concentrated) - continued		
Renewal — Indications other than cystic fibros	is		
Current approval Number (if known):			
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.  Prerequisites(tick box, and write the data requested in the space provided where appropriate)			
The treatment remains appropriate and the patient is benefiting from treatment and  General Practitioners must include the name of the dietitian, relevant specialist or vocationally registered general practitioner and date contacted			
COTITACIEU			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 422 Form SA1106 June 2025

APPL	ICANT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg N	0:	First Names:	First Names:
Name		Surname:	Surname:
Addre	ss:	DOB:	Address:
		Address:	
Fax N	umber:		Fax Number:
Food	Thickeners (Karicare Food Thickener; N	utilis)	
Appli	l application cations only from a dietitian, relevant specialisequisites(tick box where appropriate)  The patient has motor neurone disease was a second or categories.	st or vocationally registered general practitioner. App	rovals valid for 1 year.
Rene	wal		
Appli dietiti	cations only from a dietitian, relevant specialis	st, vocationally registered general practitioner or gene ed general practitioner. Approvals valid for 1 year.	eral practitioner on the recommendation of a
	and General Practitioners must include the n	e and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 423 **Form SA1729** 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:				
Gluten Free Foods (Bakels Gluten Free Healt Baking Mix)	h Bread Mix; Horleys Bread Mix; Horleys Flour; NZB	Low Gluten Bread Mix; Orgran; Healtheries Simple				
Initial application — all patients Applications only from a dietitian, relevant specialis Prerequisites(tick boxes where appropriate)	st or vocationally registered general practitioner. App	rovals valid without further renewal unless notified.				
Gluten enteropathy has been diagr	nosed by biopsy					
Patient suffers from dermatitis herp	petiformis					
Initial application — paediatric patients diagnosed by ESPGHAN criteria Applications only from a paediatric gastroenterologist. Approvals valid without further renewal unless notified.  Prerequisites(tick box where appropriate)						
The paediatric patient fulfils ESPGHAN criteria for biopsy free diagnosis of coeliac disease						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 424 **Form SA2357** 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:				
Foods and Supplements For Inborn Er	rors Of Metabolism					
Initial application Applications from any relevant practitioner. Approv Prerequisites(tick box where appropriate)	als valid without further renewal unless notified.					
Patient requires dietary management of inherited metabolic disorders						

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 425 **Form SA1110** 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:			
nfant Formulae - For Williams Syndro	me (Locasol)				
Prerequisites(tick box where appropriate)	st or vocationally registered general practitioner. App	rovals valid for 1 year.			
Renewal					
Current approval Number (if known):					
Applications only from a dietitian, relevant specialist, vocationally registered general practitioner or general practitioner on the recommendation of a dietitian, relevant specialist or vocationally registered general practitioner. Approvals valid for 1 year.					
Prerequisites(tick box, and write the data request	• • •				
and General Practitioners must include the n	and the patient is benefiting from treatment ame of the dietitian, relevant specialist or vocationally				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 426 **Form SA2092** 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:
Amino acid formula (Alfamino Junior; Elecare	; Neocate)	
Extensively hydrolysed formu intolerance or allergy or mala	als valid for 6 months.  A protein formula or dairy products  been trialled in an inpatient setting and is clinically in the setting	inappropriate due to documented severe

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 427 **Form SA2092** June 2025

APPLICANT (stamp or sticker acceptable)			stick	er acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name:						Surname:	Surname:
Address	:					DOB:	Address:
						Address:	
Fax Nun	nber:						Fax Number:
Amino	aci	id fo	ormu	ıla (A	Alfamino Junior; Elecar	e; Neocate) - continued	
paediatric gastroenterologist or paediatric immuno  Prerequisites(tick boxes where appropriate)  Applicant is a paediatrician or Applicant is a dietitian and consulted within the last 12 and  History of anaphylaxis to coor Eosinophilic oesophagitis or Ultra-short gut or Severe Immune deficiency or		st or paediatric immuno where appropriate) icant is a paediatrician, icant is a dietitian and coulted within the last 12 ory of anaphylaxis to co	gastroenterologist, paediatric immunologist or dietitian on the recommendation of a paediatrician, plogist. Approvals valid for 6 months.  paediatric gastroenterologist or paediatric immunologist confirms that a paediatrician, paediatric gastroenterologist or paediatric immunologist has been months and has recommended treatment for the patient  w's milk protein formula or dairy products				
		or [	or [ or		Seve	ere Immune deficiency	ula has been trialled in an inpatient setting and is clin
			and	∐ '		d formula has been reasonably trialled for 2-4 weeks allergy or malabsorption	and is inappropriate due to documented
				or	. —	a valid Special Authority approval for extensively hyd	drolysed formula: approval number

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 428 **Form SA2092** June 2025

APPLICANT (stamp or sticker acceptable)			sticker acceptable)	PATIENT NHI:	REFERRER Reg No:
Reg No:				First Names:	First Names:
Name:				Surname:	Surname:
Address: .				DOB:	Address:
				Address:	
			<b>la</b> (Alfamino Junior; Elecare	o: Neocate) - continued	Fax Number:
Renewal Current a Application	— Infa pproval ons from	nts up Numb	o to 12 months of age oer (if known):elevant practitioner. Approves where appropriate)		
O. C.	and	and and and	formula has been und The outcome of the as Amino acid formula is	ic to cow's milk whether the infant can be transitioned to a cow's milk	
or	and		An assessment as to formula has been und  The outcome of the as  Amino acid formula is	ed severe gastrointestinal intolerance (including eosin whether the infant can be transitioned to a cow's milk lertaken assessment is that the infant continues to require an a required for a nutritional deficit three months from the previous approval	protein, soy, or extensively hydrolysed infant

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 429 **Form SA2092** 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:			
	:id formula (Alfamino Junior; Elecar	e; Neocate) - continued	Fax Number:		
Current app		gastroenterologist, paediatric immunologist or dietitia	n on the recommendation of a paediatrician,		
-	astroenterologist or paediatric immuno tes(tick boxes where appropriate)	ologist. Approvals valid for 6 months.			
and	Applicant is a dietitian and of consulted within the last 12  History of anaphylaxis to coor  Eosinophilic oesophagitis  Or  Ultra-short gut  Or  Extensively hydrolysed form or  Extensively hydrolysed form or  The patient has or	paediatric gastroenterologist or paediatric immunoloconfirms that a paediatrician, paediatric gastroenterologist or paediatric gastroenterologist months and has recommended treatment for the patients with a protein formula or dairy products  and has been trialled in an inpatient setting and is clind formula has been reasonably trialled for 2-4 weeks allergy or malabsorption  a valid Special Authority approval for extensively hydroediated allergy	ogist or paediatric immunologist has been ient  nically inappropriate s and is inappropriate due to documented		
Initial appli	ication for nationts who have a su	urrent funding under Chesial Authority form CA15			
Applications		Irrent funding under Special Authority form SA15 st or vocationally registered general practitioner. App			
Patient has a valid Special Authority approval for extensively hydrolysed formula (SA1557) and					
and		ptamil Gold+ Pepti Junior, AllerPro SYNEO 1 and 2)	is unable to be supplied at this time		
		ed dispensings of Neocate Gold and Neocate Syneo			
	Note: This criteria is short term funding to cover an out-of-stock situation on some extensively hydrolysed formula powder funded under Special Authority form SA1557. There is no renewal criteria under this restriction.				

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 430 **Form SA1557** June 2025

APPLICA	NT (stamp or sticker acceptable)	PATIENT NHI:	REFERRER Reg No:			
Reg No: .		First Names:	First Names:			
Name:		Surname:	Surname:			
Address:		DOB:	Address:			
		Address:				
	er:vely hydrolysed formula		Fax Number:			
Initial ap	plication ons only from a dietitian, relevant speciali	st or vocationally registered general practitioner. Appested in the space provided where appropriate)	rovals valid for 6 months.			
	Cows milk formula is inappro	opriate due to severe intolerance or allergy to its prote	ein content			
		been reasonably trialled without resolution of symptoms onsidered clinically inappropriate or contraindicated				
	or Soy milk formula is co					
or or	Severe malabsorption					
or	Short bowel syndrome					
or	Intractable diarrhoea					
	Biliary atresia					
or	Cholestatic liver diseases causing	g malsorption				
or	Cystic fibrosis					
or	Proven fat malabsorption					
or		s causing significant malabsorption				
or	Intestinal failure					
	For step down from Amino A	cid Formula				
	The infant is currently receiv	ing funded amino acid formula				
		, or transitioned to, an extensively hydrolysed formula	a			
		e the name of the dietitian, relevant specialist or voca				
Note: A r	easonable trial is defined as a 2-4 week	rial, or signs of an immediate IgE mediated allergic re	eaction.			

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 431 **Form SA1557** 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:				
Extensively hydrolysed formula - continu	red					
Renewal						
Current approval Number (if known):						
	et, vocationally registered general practitioner or general general practitioner. Approvals valid for 6 months. sted in the space provided where appropriate)					
An assessment as to whether the in	nfant can be transitioned to a cows milk protein or so	y infant formula has been undertaken				
	that the infant continues to require an extensively hy	drolysed infant formula				
The state of the s	ame of the dietitian, relevant specialist or vocationally					

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 432 Form SA1953 June 2025

APPLICANT (stamp or sticker acceptable)			np oı	r sticker acceptable)	PATIENT NHI:	REFERRER Reg No:	
Reg No:					First Names:	First Names:	
Name	:				Surname:	Surname:	
Addre	ss:				DOB:	Address:	
					Address:		
Fax N	umber	r:				Fax Number:	
Ente	ral lic	quid	pep	otide formula (Nutrini Pe	otisorb; Nutrini Peptisorb Energy)		
Appli	cation	-	from	n a dietitian, relevant specialis xes where appropriate)	st or vocationally registered general practitioner. App	rovals valid for 6 months.	
	and	P	atier	nt has impaired gastrointestin	al function and either cannot tolerate polymeric feeds	s, or polymeric feeds are unsuitable	
		[		Severe malabsorption			
		or [		Short bowel syndrome			
		or [		Intractable diarrhoea			
		or [		Biliary atresia			
		or		Cholestatic liver diseases ca	ausing malabsorption		
		or	_	Cystic fibrosis	gg		
		or	_	•			
		or	_	Proven fat malabsorption			
		or			orders causing significant malabsorption		
		or		Intestinal failure			
			and	_	y receiving funded amino acid formula		
			an		alled on, or transitioned to, an enteral liquid peptide for	ormula	
	and		_				
		or	_	A semi-elemental or partially	hydrolysed powdered feed has been reasonably tria	lled and considered unsuitable	
		L		For step down from intraven	ous nutrition		
Note	Note: A reasonable trial is defined as a 2-4 week trial.						
Rene	wal						
Appli dietit	cation an, re	is only elevant	from spec		st, vocationally registered general practitioner or gene ed general practitioner. Approvals valid for 6 months.		
	and			sessment as to whether the la has been undertaken	patient can be transitioned to a cows milk protein or s	oy infant formula or extensively hydrolysed	
	[	Т	he o	utcome of the assessment is	that the patient continues to require an enteral liquid	peptide formula	
	and [			ral practitioners must include contacted	the name of the dietitian, relevant specialist or vocati	ionally registered general practitioner and the	

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 433 Form SA1698 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:
Paediatric oral/enteral feed 1 kcal/ml (In	fatrini)	
months.  Prerequisites(tick boxes where appropriate)  Patient is fluid restricted or volume and Patient is under the care of a paedi and Patient is under 18 months of age of Note: 'Volume intolerant' patients are those who ar	eneral practitioner on the recommendation of a paece intolerant and has been diagnosed with faltering growth atrician or dietitian who has recommended treatmenter weighs less than 8 kg  e unable to tolerate an adequate volume of infant for all alternative treatments, such as concentrating, fortif	wth with a high energy infant formula mula to achieve expected growth rate. These
Renewal Current approval Number (if known): Applications only from a paediatrician, dietitian or g Prerequisites(tick boxes where appropriate)	eneral practitioner on the recommendation of a paec	liatrician or dietitian. Approvals valid for 6 months.
Patient is under the care of a hospit and Patient is under 18 months of age of the Note: 'Volume intolerant' patients are those who are	ed or volume intolerant and has faltering growth tal paediatrician or dietitian who has recommended to br weighs less than 8 kg e unable to tolerate an adequate volume of infant for all alternative treatments, such as concentrating, fortif	mula to achieve expected growth rate. These

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 434 Form SA1197 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:			
High fat formula with vitamins, minerals and trace elements and low in protein and carbohydrate (KetoCal)					
Initial application Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 3 months.  Prerequisites(tick box where appropriate)					
The patient has intractable epilepsy, pyruvate dehydrogenase deficiency or glucose transported type-1 deficiency and other conditions requiring a ketogenic diet					
Renewal					
Current approval Number (if known):					
Applications only from a metabolic physician or paediatric neurologist. Approvals valid for 2 years.  Prerequisites(tick box where appropriate)					
The patient is on a ketogenic diet and the patient is benefiting from the diet					

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	Diazoxide			Nintedanib	
	Hydralazine			Pirfenidone	
	Itraconazole			lvacaftor	
	PropranololPyrimethamine			Acitretin	
	Glyceryl trinitrate Oint 0.2%			Pegylated Interferon alfa-2A	
CA1001	Sulfadiazine	0		Coenzyme Q10	
				Levocarnitine	
	Tetracycline			Riboflavin	
	Minocycline hydrochloride Tab 50 mg				
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	Rifaximin			Rosuvastatin	
	Midodrine			Abiraterone acetate	
	Deferiprone			Taliglucerase alfa	
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