Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2353**
August 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

**and**

- ☐ 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 transfusion in the last 4 months

**and**

- ☐ No evidence of disease progression

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

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