APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2383
November 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

Initial application
Applications only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation chemotherapy

or

- ☐ Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppressive therapy*

Renewal

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

Applications only from a haematologist or infectious disease specialist. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has acute myeloid leukaemia and is to be treated with high dose remission induction, re-induction or consolidation therapy

or

- ☐ Patient has received a stem cell transplant and has graft versus host disease and is on significant immunosuppression* and requires on going posaconazole treatment

Note: * Graft versus host disease (GVHD) on significant immunosuppression is defined as acute GVHD, grade II to IV, or extensive chronic GVHD, or if they were being treated with intensive immunosuppressive therapy consisting of either high-dose corticosteroids (1 mg or greater per kilogram of body weight per day for patients with acute GVHD or 0.8 mg or greater per kilogram every other day for patients with chronic GVHD), antithymocyte globulin, or a combination of two or more immunosuppressive agents or types of treatment.

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

and

- ☐ Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

- ☐ Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

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

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

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

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.....	.....	.....
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Posaconazole *- continued*

Renewal — Invasive fungal infection prophylaxis

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

Applications from any relevant practitioner. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ The patient is at risk of invasive fungal infection

and

☐ Posaconazole is prescribed by, or recommended by a haematologist, transplant physician, infectious disease specialist, paediatric haematologist or paediatric oncologist

or

☐ Prescribing posaconazole is in accordance with a protocol or guideline that has been endorsed by the Health New Zealand - Te Whatu Ora Hospital in the specific settings where there is a greater than 10% risk of invasive fungal infection (IFI)

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