Enquiries to Ministry of Health 0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Page 1 Form SA2461 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:
lpilimumab		
The patient has metastatic read and The patient is treatment naive and The patient has ECOG performand 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 yor Karnofsky performance and	enal cell carcinoma e e ermance status 0-2 y of clear cell histology matoid histology ss than the lower limit of normal um level greater than 10 mg/dL (2.5 mmol/L) an the upper limit of normal the upper limit of normal year from original diagnosis to the start of systemic the e score of less than or equal to 70	nerapy
or Interval of less than 1 your Karnofsky performance	year from original diagnosis to the start of systemic the	

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