Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1596
December 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

Initial application
Applications only from a haematologist or rheumatologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has severe HHV-8 negative idiopathic multicentric Castleman's Disease

and

- ☐ Treatment with an adequate trial of corticosteroids has proven ineffective

and

- ☐ Siltuximab is to be administered at doses no greater than 11 mg/kg every 3 weeks

Renewal

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

Applications only from a haematologist or rheumatologist. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient has sustained improvement in inflammatory markers and functional status

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

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