Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1895
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: .....

Fulvestrant

Initial application
Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer

and

- ☐ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease

and

- ☐ Treatment to be given at a dose of 500 mg monthly following loading doses

and

- ☐ Treatment to be discontinued at disease progression

Renewal

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

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Treatment remains appropriate and patient is benefitting from treatment

and

- ☐ Treatment to be given at a dose of 500 mg monthly

and

- ☐ There is 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 Health New Zealand, Private Bag 3015, Wanganui – email: customerservice@health.govt.nz