Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2166
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: .....

Tolvaptan

Initial application — autosomal dominant polycystic kidney disease
Applications only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has a confirmed diagnosis of autosomal dominant polycystic kidney disease

and

- ☐ Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 25 ml/min/1.73 m^2 at treatment initiation

and

- ☐ Patient's disease is rapidly progressing, with a decline in eGFR of greater than or equal to 5 mL/min/1.73 m^2 within one-year

or

- ☐ Patient's disease is rapidly progressing, with an average decline in eGFR of greater than or equal to 2.5 mL/min/1.73 m^2 per year over a five-year period

Renewal — autosomal dominant polycystic kidney disease

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

Applications only from a renal physician or any relevant practitioner on the recommendation of a renal physician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has not developed end-stage renal disease, defined as an eGFR of less than 15 mL/min/1.73 m^2

and

- ☐ Patient has not undergone a kidney transplant

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