Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2356
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: .....

Thalidomide

Initial application
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick box where appropriate)

☐ The patient has plasma cell dyscrasia, not including Waldenström macroglobulinaemia, requiring treatment

Renewal

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

Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

☐ The patient has obtained a response from treatment during the initial approval period

Note: Prescription must be written by a registered prescriber in the thalidomide risk management programme operated by the supplier.
Maximum dose of 400 mg daily as monotherapy or in a combination therapy regimen.

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