Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2385
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: .....

Dasatinib

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

- ☐ The patient has a diagnosis of chronic myeloid leukaemia (CML) in blast crisis or accelerated phase

or

- ☐ The patient has a diagnosis of Philadelphia chromosome-positive acute lymphoid leukaemia (Ph+ ALL)

or

- ☐ The patient has a diagnosis of CML in chronic phase

and

  - ☐ Patient has documented treatment failure* with imatinib

  or

  - ☐ Patient has experienced treatment-limiting toxicity with imatinib precluding further treatment with imatinib

  or

  - ☐ Patient has high-risk chronic-phase CML defined by the Sokal or EURO scoring system

Renewal

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

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

- ☐ Lack of treatment failure while on dasatinib*

and

- ☐ Dasatinib treatment remains appropriate and the patient is benefiting from treatment

Note: *treatment failure for CML as defined by Leukaemia Net Guidelines.

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