Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2289
January 2026

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: .....

Brentuximab

Initial application — relapsed/refractory Hodgkin lymphoma
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma after two or more lines of chemotherapy
  and
- ☐ Patient is ineligible for autologous stem cell transplant

or

- ☐ Patient has relapsed/refractory CD30-positive Hodgkin lymphoma
  and
- ☐ Patient has previously undergone autologous stem cell transplant

and
☐ Patient has not previously received funded brentuximab vedotin
and
☐ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and
☐ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

Renewal — relapsed/refractory Hodgkin lymphoma

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

Applications from any relevant practitioner. Approvals valid for 9 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles
and
☐ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated
and
☐ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

Initial application — anaplastic large cell lymphoma
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has relapsed/refractory CD30-positive systemic anaplastic large cell lymphoma
and
☐ Patient has an ECOG performance status of 0-1
and
☐ Patient has not previously received brentuximab vedotin
and
☐ Response to brentuximab vedotin treatment is to be reviewed after a maximum of 6 treatment cycles
and
☐ Brentuximab vedotin to be administered at doses no greater than 1.8 mg/kg every 3 weeks

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

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: .....

Brentuximab *- continued*

Renewal — anaplastic large cell lymphoma

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

Applications from any relevant practitioner. Approvals valid for 9 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has achieved a partial or complete response to brentuximab vedotin after 6 treatment cycles

and

☐ Treatment remains clinically appropriate and the patient is benefitting from treatment and treatment is being tolerated

and

☐ Patient is to receive a maximum of 16 total cycles of brentuximab vedotin treatment

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