Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2514
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: .....

Valganciclovir

Initial application — transplant cytomegalovirus prophylaxis
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

☐ The patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis

Renewal — transplant cytomegalovirus prophylaxis

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

Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis

and

☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin

or

☐ Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis

and

☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone

Initial application — cytomegalovirus prophylaxis following anti-thymocyte globulin
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months)

and

☐ Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

Renewal — cytomegalovirus prophylaxis following anti-thymocyte globulin

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

Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

☐ The patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

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

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Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Valganciclovir *- continued*

Initial application — Lung transplant cytomegalovirus prophylaxis
Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone a lung transplant

and

- ☐ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

or

- ☐ The recipient is cytomegalovirus positive

and

- ☐ Patient has a high risk of CMV disease

Renewal — Lung transplant cytomegalovirus prophylaxis

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

Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone a lung re-transplant

and

- ☐ The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

or

- ☐ The recipient is cytomegalovirus positive

and

- ☐ Patient has a high risk of CMV disease

Initial application — Cytomegalovirus in immunocompromised patients
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is immunocompromised

and

- ☐ Patient has cytomegalovirus syndrome or tissue invasive disease

or

- ☐ Patient has rapidly rising plasma CMV DNA in absence of disease

or

- ☐ Patient has cytomegalovirus retinitis

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: .....
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Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Valganciclovir *- continued*

Renewal — Cytomegalovirus in immunocompromised patients

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

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

☐ Patient is immunocompromised

and

☐ Patient has cytomegalovirus syndrome or tissue invasive disease

or

☐ Patient has rapidly rising plasma CMV DNA in absence of disease

or

☐ Patient has cytomegalovirus retinitis

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....