Enquiries to Ministry of Health
0800 855 066

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**Form SA2534**
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: ..... |

## Pertuzumab with trastuzumab

**Initial application — metastatic breast cancer**
Applications from any relevant practitioner. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

☐ The individual has received an initial Special Authority approval for intravenous pertuzumab and trastuzumab for metastatic breast cancer

**and**

☐ Pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)

**or**

☐ The patient has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

**and**

☐ Patient is chemotherapy treatment naïve

**or**

☐ Patient has not received prior treatment for their metastatic disease and has had a treatment free interval of at least 12 months between prior (neo)adjuvant chemotherapy treatment and diagnosis of metastatic breast cancer

**and**

☐ The patient has good performance status (ECOG grade 0-1)

**and**

☐ Loading dose of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 1200 mg pertuzumab with 600 mg trastuzumab, respectively

**and**

☐ Maintenance doses of pertuzumab with trastuzumab to be administered subcutaneously at a maximum dose of 600 mg pertuzumab with 600 mg trastuzumab every three weeks (or equivalent)

**and**

☐ Pertuzumab with trastuzumab to be discontinued at disease progression

**Renewal — metastatic breast cancer**

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

Applications from any relevant practitioner. Approvals valid for 12 months.
**Prerequisites**(tick boxes where appropriate)

☐ The individual has metastatic breast cancer expressing HER-2 IHC 3+ or ISH+ (including FISH or other current technology)

**and**

☐ The cancer has not progressed at any time point during the previous 12 months whilst on pertuzumab and trastuzumab

**or**

☐ Individual has previously discontinued treatment with pertuzumab with trastuzumab for reasons other than severe toxicity or disease progression

**and**

☐ Individual has signs of disease progression

**and**

☐ Disease has not progressed during previous treatment with pertuzumab with trastuzumab

**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**