Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2345
February 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: .....

Palbociclib (Ibrance)

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

- ☐ Patient has unresectable locally advanced or metastatic breast cancer
- **and** ☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative
- **and** ☐ Patient has an ECOG performance score of 0-2
- **and**
  - ☐ Disease has relapsed or progressed during prior endocrine therapy
  - **or**
    - ☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
    - **and** ☐ Patient has not received prior systemic treatment for metastatic disease
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ Patient has not received prior funded treatment with a CDK4/6 inhibitor

or

- ☐ Patient has an active Special Authority approval for ribociclib
- **and** ☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of ribociclib

Renewal

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

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

- ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of palbociclib

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