Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2550
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: .....

Aflibercept

Initial application — diabetic macular oedema
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has centre involving diabetic macular oedema (DMO)

and

- ☐ Patient's disease is non responsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly

and

- ☐ Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision

and

- ☐ Patient has DMO within central OCT (ocular coherence tomography) subfield > 350 micrometers

and

- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

and

- ☐ Patient has not previously been treated with faricimab for longer than 3 months

Renewal — diabetic macular oedema

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

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

- ☐ There is stability or two lines of Snellen visual acuity gain

and

- ☐ There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)

and

- ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score

and

- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

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: .....

Aflibercept *- continued*

Initial application — wet age related macular degeneration
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Wet age-related macular degeneration (wet AMD)
  - **or** ☐ Polypoidal choroidal vasculopathy
  - **or** ☐ Choroidal neovascular membrane from causes other than wet AMD

and

- ☐ The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
  - **or** ☐ There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and ☐ There is no structural damage to the central fovea of the treated eye

and ☐ Patient has not previously been treated with ranibizumab or faricimab for longer than 3 months

or

- ☐ Patient has current approval to use ranibizumab or faricimab for treatment of wAMD and was found to be intolerant within 3 months
  - **or** ☐ Patient has previously* (*before June 2018) received treatment with ranibizumab for wAMD and disease was stable while on treatment

Renewal — wet age related macular degeneration

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

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

☐ Documented benefit must be demonstrated to continue

and ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score

and ☐ There is no structural damage to the central fovea of the treated eye

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

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

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