Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2174
March 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: .....

Nusinersen

Initial application — spinal muscular atrophy (SMA)
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has genetic documentation of homozygous SMN1 gene deletion, homozygous SMN1 point mutation, or compound heterozygous mutation

and

- ☐ Patient is 18 years of age or under

and

- ☐ Patient has experienced the defined signs and symptoms of SMA type I, II or IIIa prior to three years of age

or

- ☐ Patient is pre-symptomatic

and

- ☐ Patient has three or less copies of SMN2

Renewal — spinal muscular atrophy (SMA)

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

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

- ☐ There has been demonstrated maintenance of motor milestone function since treatment initiation

and

- ☐ Patient does not require invasive permanent ventilation (at least 16 hours per day) in the absence of a potentially reversible cause while being treated with nusinersen

and

- ☐ Nusinersen not to be administered in combination other SMA disease modifying treatments or gene therapy

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