Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2443
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: .....

Atezolizumab

Initial application — non-small cell lung cancer second line monotherapy
Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has locally advanced or metastatic non-small cell lung cancer

and

- ☐ Patient has not received prior funded treatment with an immune checkpoint inhibitor for NSCLC

and

- ☐ For patients with non-squamous histology there is documentation confirming that the disease does not express activating mutations of EGFR or ALK tyrosine kinase unless not possible to ascertain

and

- ☐ Patient has an ECOG 0-2

and

- ☐ Patient has documented disease progression following treatment with at least two cycles of platinum-based chemotherapy

and

- ☐ Atezolizumab is to be used as monotherapy at a dose of 1200 mg every three weeks (or equivalent) for a maximum of 16 weeks

and

- ☐ Baseline measurement of overall tumour burden is documented clinically and radiologically

Renewal — non-small cell lung cancer second line monotherapy

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

Applications only from a medical oncologist or any relevant practitioner on the recommendation of a medical oncologist. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient's disease has had a complete response to treatment

or

- ☐ Patient's disease has had a partial response to treatment

or

- ☐ Patient has stable disease

and

- ☐ Response to treatment in target lesions has been determined by comparable radiologic assessment following the most recent treatment period

and

- ☐ No evidence of disease progression

and

- ☐ The treatment remains clinically appropriate and patient is benefitting from treatment

and

- ☐ Atezolizumab to be used at a maximum dose of 1200 mg every three weeks (or equivalent)

and

- ☐ Treatment with atezolizumab to cease after a total duration of 24 months from commencement (or equivalent of 35 cycles dosed every 3 weeks)

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: .....
Reg No:	First Names:	First Names: .....
Name:	Surname:	Surname: .....
Address:	DOB:	Address: .....
.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Atezolizumab *- continued*

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

- ☐ Patient is currently on treatment with atezolizumab and met all remaining criteria prior to commencing treatment

or

- ☐ Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma

and

- ☐ Patient has preserved liver function (Child-Pugh A)

and

- ☐ Transarterial chemoembolisation (TACE) is unsuitable

and

- ☐ Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma

or

- ☐ Patient received funded lenvatinib before 1 March 2025

or

- ☐ Patient has experienced treatment-limiting toxicity from treatment with lenvatinib

and

- ☐ No disease progression since initiation of lenvatinib

and

- ☐ Patient has an ECOG performance status of 0-2

and

- ☐ To be given in combination with bevacizumab

Renewal — unresectable hepatocellular carcinoma

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

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

- ☐ There is no evidence of disease progression

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