Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2480
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: .....

Ibrutinib

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

- ☐ Individual has chronic lymphocytic leukaemia (CLL) requiring therapy
- **and**
- ☐ Individual has not previously received funded ibrutinib
- **and**
- ☐ Ibrutinib is to be used as monotherapy
- **and**
  - ☐ There is documentation confirming that the individual has 17p deletion or TP53 mutation
  - **and**
  - ☐ Individual has experienced intolerable side effects with venetoclax monotherapy
  - **or**
  - ☐ Individual has received at least one prior immunochemotherapy for CLL
  - **and**
  - ☐ Individual's CLL has relapsed
  - **and**
  - ☐ Individual has experienced intolerable side effects with venetoclax in combination with rituximab regimen
  - **or**
  - ☐ Individual's CLL is refractory to or has relapsed following a venetoclax regimen

Renewal — chronic lymphocytic leukaemia (CLL)

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

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

- ☐ There is no evidence of disease progression

Note: 'Chronic lymphocytic leukaemia (CLL)' includes small lymphocytic lymphoma (SLL) and B-cell prolymphocytic leukaemia (B-PLL)*. Indications marked with * are Unapproved indications.

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