Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY
BY SPECIAL AUTHORITY

Form SA2514
March 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Valganciclovir

Initial application — transplant cytomegalovirus prophylaxis
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

☐ The patient has undergone a solid organ transplant and requires valganciclovir for CMV prophylaxis

---

Renewal — transplant cytomegalovirus prophylaxis

Current approval Number (if known):...

Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received anti-thymocyte globulin and requires valganciclovir therapy for CMV prophylaxis

and

☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following anti-thymocyte globulin

or

☐ Patient has received pulse methylprednisolone for acute rejection and requires further valganciclovir therapy for CMV prophylaxis

and

☐ Patient is to receive a maximum of 90 days of valganciclovir prophylaxis following pulse methylprednisolone

---

Initial application — cytomegalovirus prophylaxis following anti-thymocyte globulin
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has undergone a solid organ transplant and received valganciclovir under Special Authority more than 2 years ago (27 months)

and

☐ Patient has received anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

---

Renewal — cytomegalovirus prophylaxis following anti-thymocyte globulin

Current approval Number (if known):...

Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

☐ The patient has received a further course of anti-thymocyte globulin and requires valganciclovir for CMV prophylaxis

---

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

APPLICATION FOR SUBSIDY
BY SPECIAL AUTHORITY

Form SA2514
March 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Valganciclovir *- continued*

Initial application — Lung transplant cytomegalovirus prophylaxis
Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient has undergone a lung transplant

and

- [ ] The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

or

- [ ] The recipient is cytomegalovirus positive

and

- [ ] Patient has a high risk of CMV disease

Renewal — Lung transplant cytomegalovirus prophylaxis

Current approval Number (if known):..

Applications only from a relevant specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient has undergone a lung re-transplant

and

- [ ] The donor was cytomegalovirus positive and the patient is cytomegalovirus negative

or

- [ ] The recipient is cytomegalovirus positive

and

- [ ] Patient has a high risk of CMV disease

Initial application — Cytomegalovirus in immunocompromised patients
Applications only from a relevant specialist. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- [ ] Patient is immunocompromised

and

- [ ] Patient has cytomegalovirus syndrome or tissue invasive disease

or

- [ ] Patient has rapidly rising plasma CMV DNA in absence of disease

or

- [ ] Patient has cytomegalovirus retinitis

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

Enquiries to Ministry of Health
0800 855 066

**APPLICATION FOR SUBSIDY
BY SPECIAL AUTHORITY**

Form SA2514
March 2026

APPLICANT (stamp or sticker acceptable)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Valganciclovir *- continued*

Renewal — Cytomegalovirus in immunocompromised patients

Current approval Number (if known):..

Applications only from a relevant specialist. Approvals valid for 3 months.

Prerequisites(tick boxes where appropriate)

☐ Patient is immunocompromised

and

☐ Patient has cytomegalovirus syndrome or tissue invasive disease

or

☐ Patient has rapidly rising plasma CMV DNA in absence of disease

or

☐ Patient has cytomegalovirus retinitis

Note: for the purpose of this Special Authority "immunocompromised" includes transplant recipients, patients with immunosuppressive diseases (e.g. HIV) or those receiving immunosuppressive treatment for other conditions.

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