Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2445
April 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: .....

Long-acting Somatostatin Analogues

Initial application — Malignant Bowel Obstruction
Applications from any relevant practitioner. Approvals valid for 2 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has nausea* and vomiting* due to malignant bowel obstruction*

and

- ☐ Treatment with antiemetics, rehydration, antimuscarinic agents, corticosteroids and analgesics for at least 48 hours has not been successful

and

- ☐ Treatment to be given for up to 4 weeks

Note: Indications marked with * are unapproved indications.

Renewal — Malignant Bowel Obstruction

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

Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

Initial application — Acromegaly
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has acromegaly

and

- ☐ Treatment with surgery and radiotherapy is not suitable or was unsuccessful

or

- ☐ Treatment is for an interim period while awaiting the beneficial effects of radiotherapy

and

- ☐ Treatment with a dopamine agonist has been unsuccessful

Renewal — Acromegaly

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

Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

- ☐ IGF1 levels have decreased since starting treatment

Note: In patients with acromegaly, treatment should be discontinued if IGF1 levels have not decreased 3 months after treatment. In patients treated with radiotherapy treatment should be withdrawn every 2 years, for 1 month, for assessment of remission. Treatment should be stopped where there is biochemical evidence of remission (normal IGF1 levels) following treatment withdrawal for at least 4 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

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.....	Address:	.....
.....	.....	.....
Fax Number:	.....	Fax Number: .....

Long-acting Somatostatin Analogues *- continued*

Initial application — pre-operative acromegaly
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has acromegaly
- **and**
- ☐ Patient has a large pituitary tumour, greater than 10 mm at its widest
- **and**
- ☐ Patient is scheduled to undergo pituitary surgery in the next six months

Initial application — Other Indications
Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick boxes where appropriate)

- ☐ VIPomas and Glucagonomas - for patients who are seriously ill in order to improve their clinical state prior to definitive surgery
- **or**
- ☐ Gastrinoma
- **and**
- ☐ Surgery has been unsuccessful
- **or**
- ☐ Patient has metastatic disease after treatment with H2 antagonist or proton pump inhibitors has been unsuccessful
- **or**
- ☐ Insulinomas
- **and**
- ☐ Surgery is contraindicated or has not been successful
- **or**
- ☐ For pre-operative control of hypoglycaemia and for maintenance therapy
- **or**
- ☐ Carcinoid syndrome (diagnosed by tissue pathology and/or urinary 5HIAA analysis)
- **and**
- ☐ Disabling symptoms not controlled by maximal medical therapy

Note: The use of a long-acting somatostatin analogue in patients with fistulae, oesophageal varices, miscellaneous diarrhoea and hypotension will not be funded under Special Authority

Renewal — Other Indications

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

Applications from any relevant practitioner. Approvals valid for 2 years.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefiting from treatment

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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