Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1895
May 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: ....

Fulvestrant

Initial application
Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ Patient has oestrogen-receptor positive locally advanced or metastatic breast cancer

and
☐ Patient has disease progression following prior treatment with an aromatase inhibitor or tamoxifen for their locally advanced or metastatic disease

and
☐ Treatment to be given at a dose of 500 mg monthly following loading doses

and
☐ Treatment to be discontinued at disease progression

Renewal

Current approval Number (if known):..

Applications only from a medical oncologist or medical practitioner on the recommendation of a medical oncologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

☐ Treatment remains appropriate and patient is benefitting from treatment

and
☐ Treatment to be given at a dose of 500 mg monthly

and
☐ 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