Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA1978
May 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: .....

Dornase Alfa

Initial application — cystic fibrosis
Applications only from a respiratory physician or paediatrician. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has a confirmed diagnosis of cystic fibrosis

and

- ☐ Patient has previously undergone a trial with, or is currently being treated with, hypertonic saline

and

- ☐ Patient has required one or more hospital inpatient respiratory admissions in the previous 12 month period

or

- ☐ Patient has had 3 exacerbations due to CF, requiring oral or intravenous (IV) antibiotics in the previous 12 month period

or

- ☐ Patient has had 1 exacerbation due to CF, requiring oral or IV antibiotics in the previous 12 month period and a Brasfield score of < 22/25

or

- ☐ Patient has a diagnosis of allergic bronchopulmonary aspergillosis (ABPA)

Renewal — cystic fibrosis

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

Applications only from a respiratory physician or paediatrician. Approvals valid without further renewal unless notified.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient continues to benefit from treatment

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