Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2034
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: .....

Pegylated Interferon alfa-2A

Initial application — chronic hepatitis C - genotype 1, 4, 5 or 6 infection or co-infection with HIV or genotype 2 or 3 post liver transplant
Applications from any specialist. Approvals valid for 18 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1, 4, 5 or 6 infection
  or
- ☐ Patient has chronic hepatitis C and is co-infected with HIV
  or
- ☐ Patient has chronic hepatitis C genotype 2 or 3 and has received a liver transplant

and

- ☐ Maximum of 48 weeks therapy

Renewal — Chronic hepatitis C - genotype 1 infection

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

Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1

and

- ☐ Patient has had previous treatment with pegylated interferon and ribavirin

and

- ☐ Patient has responder relapsed
  or
- ☐ Patient was a partial responder

and

- ☐ Patient is to be treated in combination with boceprevir

and

- ☐ Maximum of 48 weeks therapy

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

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: .....

Pegylated Interferon alfa-2A *- continued*

Initial application — Chronic Hepatitis C - genotype 1 infection treatment more than 4 years prior
Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 1

and

- ☐ Patient has had previous treatment with pegylated interferon and ribavirin

and

- ☐ Patient has responder relapsed

or

- ☐ Patient was a partial responder

or

- ☐ Patient received interferon treatment prior to 2004

and

- ☐ Patient is to be treated in combination with boceprevir

and

- ☐ Maximum of 48 weeks therapy

Initial application — chronic hepatitis C - genotype 2 or 3 infection without co-infection with HIV
Applications from any specialist. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has chronic hepatitis C, genotype 2 or 3 infection

and

- ☐ Maximum of 6 months therapy

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

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: .....

Pegylated Interferon alfa-2A *- continued*

Initial application — Hepatitis B
Applications only from a gastroenterologist, infectious disease specialist or general physician. Approvals valid for 18 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has confirmed Hepatitis B infection (HBsAg positive for more than 6 months)
- **and** ☐ Patient is Hepatitis B treatment-naive
- **and** ☐ ALT > 2 times Upper Limit of Normal
- **and** ☐ HBV DNA < 10 log10 IU/ml
- **and**
  - ☐ HBeAg positive
  - **or** ☐ Serum HBV DNA greater than or equal to 2,000 units/ml and significant fibrosis (Metavir Stage F2 or greater or moderate fibrosis)
- **and** ☐ Compensated liver disease
- **and** ☐ No continuing alcohol abuse or intravenous drug use
- **and** ☐ Not co-infected with HCV, HIV or HDV
- **and** ☐ Neither ALT nor AST > 10 times upper limit of normal
- **and** ☐ No history of hypersensitivity or contraindications to pegylated interferon
- **and** ☐ Maximum of 48 weeks therapy

Initial application — myeloproliferative disorder or cutaneous T cell lymphoma
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has a cutaneous T cell lymphoma*
- **or**
  - ☐ Patient has a myeloproliferative disorder*
  - **and** ☐ Patient is intolerant of hydroxyurea
  - **and** ☐ Treatment with anagrelide and busulfan is not clinically appropriate
- **or**
  - ☐ Patient has a myeloproliferative disorder
  - **and** ☐ Patient is pregnant, planning pregnancy or lactating

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

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: .....

Pegylated Interferon alfa-2A *- continued*

Renewal — myeloproliferative disorder or cutaneous T cell lymphoma

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

Applications from any relevant practitioner. Approvals valid for 12 months.

Prerequisites(tick boxes where appropriate)

- ☐ No evidence of disease progression
- **and**
- ☐ The treatment remains appropriate and patient is benefitting from treatment
- **and**
- ☐ Patient has a cutaneous T cell lymphoma*
- **or**
- ☐ Patient has a myeloproliferative disorder*
- **and**
- ☐ Remains intolerant of hydroxyurea and treatment with anagrelide and busulfan remains clinically inappropriate
- **or**
- ☐ Patient is pregnant, planning pregnancy or lactating

Note: Indications marked with * are unapproved indications.

Initial application — post-allogenic bone marrow transplant

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

☐ Patient has received an allogeneic bone marrow transplant* and has evidence of disease relapse

Renewal — post-allogenic bone marrow transplant

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

Applications from any relevant practitioner. Approvals valid for 3 months.

Prerequisites(tick box where appropriate)

☐ Patient is responding and ongoing treatment remains appropriate

Note: 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