Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2453
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: ....

Bevacizumab

Initial application — unresectable hepatocellular carcinoma
Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is currently on treatment with bevacizumab, and met all remaining criteria prior to commencing treatment

or

- ☐ Patient has locally advanced or metastatic, unresectable hepatocellular carcinoma
- **and** ☐ Patient has preserved liver function (Child-Pugh A)
- **and** ☐ Transarterial chemoembolisation (TACE) is unsuitable
- **and**
  - ☐ Patient has not received prior systemic therapy for the treatment of hepatocellular carcinoma
  - **or** ☐ Patient received funded lenvatinib before 1 March 2025
  - **or**
    - ☐ Patient has experienced treatment-limiting toxicity from treatment with lenvatinib
    - **and** ☐ No disease progression since initiation of lenvatinib
- **and** ☐ Patient has an ECOG performance status of 0-2
- **and** ☐ To be given in combination with atezolizumab

Renewal — unresectable hepatocellular carcinoma

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

Applications from any relevant practitioner. Approvals valid for 6 months.
Prerequisites(tick box where appropriate)

- ☐ 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

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Fax Number: ....

Bevacizumab *- continued*

Initial application — advanced or metastatic ovarian cancer
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ The patient has FIGO Stage IV epithelial ovarian, fallopian tube, or primary peritoneal cancer

  or

  - ☐ The patient has previously untreated advanced (FIGO Stage IIIB or IIIC) epithelial ovarian, fallopian tube, or primary peritoneal cancer

    and

    - ☐ Debulking surgery is inappropriate

      or

    - ☐ The cancer is sub-optimally debulked (maximum diameter of any gross residual disease greater than 1cm)

and

- ☐ Bevacizumab to be administered at a maximum dose of 15 mg/kg every three weeks

and

- ☐ 18 weeks concurrent treatment with chemotherapy is planned

Renewal — advanced or metastatic ovarian cancer

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick box where appropriate)

- ☐ There is no evidence of disease progression

Initial application — Recurrent Respiratory Papillomatosis
Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Maximum of 6 doses

and

- ☐ The patient has recurrent respiratory papillomatosis

and

- ☐ The treatment is for intra-lesional administration

Renewal — Recurrent Respiratory Papillomatosis

Current approval Number (if known):..

Applications from any relevant practitioner. Approvals valid for 12 months.
Prerequisites(tick boxes where appropriate)

- ☐ Maximum of 6 doses

and

- ☐ The treatment is for intra-lesional administration

and

- ☐ There has been a reduction in surgical treatments or disease regrowth as a result of 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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**APPLICATION FOR SUBSIDY
BY SPECIAL AUTHORITY**

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Reg No:	First Names:	First Names: ....
Name:	Surname:	Surname: ....
Address:	DOB:	Address: ....
....	Address:	....
....	....	....
Fax Number:	....	Fax Number: ....

Bevacizumab *- continued*

Initial application — Ocular Conditions
Applications from any relevant practitioner. Approvals valid without further renewal unless notified.
Prerequisites(tick boxes where appropriate)

- ☐ Ocular neovascularisation

or

- ☐ Exudative ocular angiopathy

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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