Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2533
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: ....

Faricimab

Initial application — diabetic macular oedema
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has centre involving diabetic macular oedema (DMO)

and
- ☐ Patient's disease is nonresponsive to 4 doses of intravitreal bevacizumab when administered 4-6 weekly

and
- ☐ Patient has reduced visual acuity between 6/9 – 6/36 with functional awareness of reduction in vision

and
- ☐ Patient has DMO within central OCT (ocular coherence tomography) subfield $>$ 350 micrometers

and
- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

and
- ☐ Patient has not previously been treated with aflibercept for longer than 3 months

Renewal — diabetic macular oedema
Current approval Number (if known):............

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

- ☐ There is stability or two lines of Snellen visual acuity gain

and
- ☐ There is structural improvement on OCT scan (with reduction in intra-retinal cysts, central retinal thickness, and sub-retinal fluid)

and
- ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score

and
- ☐ There is no centre-involving sub-retinal fibrosis or foveal atrophy

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)

Reg No: ....

Name: ....

Address: ....

....

....

Fax Number: ....

PATIENT NHI: ....

First Names: ....

Surname: ....

DOB: ....

Address: ....

....

....

REFERRER Reg No: ....

First Names: ....

Surname: ....

Address: ....

....

....

Fax Number: ....

Faricimab *- continued*

Initial application — wet age related macular degeneration
Applications from any relevant practitioner. Approvals valid for 3 months.
Prerequisites(tick boxes where appropriate)

- ☐ Wet age-related macular degeneration (wet AMD)
- **or** ☐ Polypoidal choroidal vasculopathy
- **or** ☐ Choroidal neovascular membrane from causes other than wet AMD

and

- ☐ The patient has developed severe endophthalmitis or severe posterior uveitis following treatment with bevacizumab
- **or** ☐ There is worsening of vision or failure of retina to dry despite three intraocular injections of bevacizumab four weeks apart

and ☐ There is no structural damage to the central fovea of the treated eye

and ☐ Patient has not previously been treated with ranibizumab or aflibercept for longer than 3 months

Renewal — wet age related macular degeneration

Current approval Number (if known):..

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

- ☐ Patient's vision is 6/36 or better on the Snellen visual acuity score
- **and** ☐ There is no structural damage to the central fovea of the treated eye

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: .... Date: ....