Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2555
June 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: ....

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

- ☐ Patient has been diagnosed with gout

and

- ☐ The patient has a serum urate level greater than 0.36 mmol/l despite treatment with allopurinol at doses of at least 600 mg/day and addition of probenecid at doses of up to 2 g per day or maximum tolerated dose

or

- ☐ The patient has experienced intolerable side effects from allopurinol such that treatment discontinuation is required and serum urate remains greater than 0.36 mmol/l despite use of probenecid at doses of up to 2 g per day or maximum tolerated dose

or

- ☐ The patient has renal impairment such that probenecid is contraindicated or likely to be ineffective and serum urate remains greater than 0.36 mmol/l despite optimal treatment with allopurinol

or

- ☐ The patient has previously had an initial Special Authority approval for benzbromarone for treatment of gout.

Initial application — Tumour lysis syndrome
Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.
Prerequisites(tick boxes where appropriate)

- ☐ Patient is scheduled to receive cancer therapy carrying an intermediate or high risk of tumour lysis syndrome

and

- ☐ Patient has a documented history of allopurinol intolerance

Renewal — Tumour lysis syndrome

Current approval Number (if known):..

Applications only from a haematologist or oncologist. Approvals valid for 6 weeks.
Prerequisites(tick box where appropriate)

- ☐ The treatment remains appropriate and the patient is benefitting 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