Enquiries to Ministry of Health
0800 855 066

APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2635
June 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: .....

Letermovir

Initial application — CMV prophylaxis - post HSCT
Applications from any relevant practitioner. Approvals valid for 4 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has undergone an allogeneic haematopoietic stem cell transplant
- **and**
- ☐ The patient has confirmed presence of cytomegalovirus-specific antibodies
- **and**
- ☐ Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
- **and**
- ☐ Maximum treatment duration of 100 days post-transplant

Renewal — CMV prophylaxis – second or subsequent HSCT

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

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

- ☐ Patient has undergone an allogeneic haematopoietic stem cell transplant
- **and**
- ☐ The patient has confirmed presence of cytomegalovirus-specific antibodies
- **and**
- ☐ Treatment to commence within 28 days of an allogeneic haematopoietic stem cell transplant
- **and**
- ☐ Maximum treatment duration of 100 days post-transplant

Initial application — CMV prophylaxis - severe immunosuppression*
Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.
Prerequisites(tick boxes where appropriate)

- ☐ Patient has severe immunosuppression requiring prophylaxis of CMV
- **and**
  - ☐ Patient is contraindicated to all other funded CMV active oral antiviral agents
  - **or**
  - ☐ Patient's CMV is resistant to all other funded CMV active oral antiviral agents

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: .....

Letermovir *- continued*

Renewal — CMV prophylaxis - severe immunosuppression*

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

Applications only from an infectious disease specialist, clinical microbiologist or any relevant practitioner on the recommendation of a infectious disease specialist or clinical microbiologist. Approvals valid for 6 months.

Prerequisites(tick boxes where appropriate)

☐ Patient has severe immunosuppression requiring prophylaxis of CMV

and

☐ Patient is contraindicated to all other funded CMV active oral antiviral agents

or

☐ Patient's CMV is resistant to all other funded CMV active oral antiviral agents

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