APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

Form SA2345
July 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: ....

Palbociclib (Ibrance)

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

- ☐ Patient has unresectable locally advanced or metastatic breast cancer
- **and** ☐ There is documentation confirming disease is hormone-receptor positive and HER2-negative
- **and** ☐ Patient has an ECOG performance score of 0-2
- **and**
  - ☐ Disease has relapsed or progressed during prior endocrine therapy
  - **or**
    - ☐ Patient is amenorrhoeic, either naturally or induced, with endocrine levels consistent with a postmenopausal or without menstrual-potential state
    - **and** ☐ Patient has not received prior systemic treatment for metastatic disease
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ Patient has not received prior funded treatment with a CDK4/6 inhibitor

or

- ☐ Patient has an active Special Authority approval for ribociclib
- **and** ☐ Patient has experienced a grade 3 or 4 adverse reaction to ribociclib that cannot be managed by dose reductions and requires treatment discontinuation
- **and** ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of ribociclib

Renewal

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

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

- ☐ Treatment must be used in combination with an endocrine partner
- **and** ☐ There is no evidence of progressive disease since initiation of palbociclib

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